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Infant Mortality: Issues and Trends

Adoption in One-Parent Families

Using Houseparents' Creativity

Service Pattern for Pregnant Teenagers

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This alert baby is a statistic only in birth records, and fortunately not in those grimmest of all records, infant mortality statistics, the subject of two articles in this issue. In contemplating vital records of any kind it is easy to lose sight of the fact that each digit in the computations involved may represent great joy or sorrow to someone. As pointed out on page 89, a continuation of a recent acceleration in the downward trend in U.S. infant mortality rates can mean that the lives of nearly 15,000 infants are spared in 1970.

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INFANT MORTALITY

an urgent national problem

FRANK FALKNER

The infant mortality rate of the United States, the richest country in the world, ranks 13th among the rates of countries with reasonably reliable data.[1] The infant mortality rate is the number of infant deaths in the first year of life per thousand live births. In 1968, the latest year for which figures are available, the rate was 21.7. In parts of the United States, however, the rates are much higher and are clustered in large urban areas and in poverty-ridden sections throughout the country. Such high rates indicate that the health of mothers and babies in this country is needlessly and grossly jeopardized.

On a worldwide basis infant mortality rates among recording countries range from an awesome 200, or even 500 in some segments of populations, down almost to 12. Moreover, in many of the less affluent countries many births and deaths go unreported. For example, it has been estimated that 1 million live births and subsequent deaths occur in India each year that are not recorded.[2]

Yet with all our affluence in medical, physical, and professional resources in the United States, we have to accept the fact that 12 countries (including France, Eastern Germany, Switzerland, and Japan as well as the Scandinavian countries) have lower infant mortality rates than we do.

Much has been written about whether comparisons between countries' infant mortality rates are valid or whether it is fair to compare the high rate in the U.S. with Sweden's, which in 1967 was 12.9, the lowest rate reported for that year to the United Nations. The validity is questioned since Sweden has a small population, a high standard of living in all social classes, and a national health service. But these differences are exactly the reasons the figures of the various nations should be compared. *How* does Sweden achieve such an admirably low rate? Careful examination of all the factors involved, and assessment of their relative importance, will lead us not only to self-examination, but will indicate the priorities for attack.

Some medical people say that comparisons between United States and Swedish figures are not valid because in Sweden "a birth need not be reported until up to 5 years after the event." [3] This statement has no basis in fact. All births and deaths in Sweden must by law be reported within 24 hours. Moreover, epidemiologists are careful to examine all the facts when international comparisons are made to find out whether adjustments or care in drawing conclusions may be necessary. Even if the statement were true, however, there would still be a basis for comparison. In Sweden, 98 percent of the births occur in hospitals, a situation that allows of reliable data collection.

Reporting of accurate data, collection of such, and definitions are obviously important if international comparisons are to be statistically sound. Some countries—particularly the developing countries—do not have the wherewithal to collect accurate figures. We guess at their infant mortality rates as best we can. But largely owing to standards set by the World

Health Organization, many countries of significant size and variation do collect and report their data in such a way as to make comparisons generally valid and proper.

Some countries are said to consider a baby who does not live for 24 hours as stillborn, and it is sometimes implied that this birth would be reported as live in the United States of America.[3] But would it? The United States has many rural and underprivileged urban areas where similar births are regarded as stillborn and where data is thus suspect. Were data in such areas accurate, it is virtually certain that our own infant mortality rate would be higher than our present estimate. This of course would also be true in some other countries.

There is another point involved. The infant mortality rate in the United States has indeed been improving, but only very slowly, in the last 15 years. The slope of decline is virtually the same in many countries other than the United States even though their rates may be better or worse than ours. But the annual rate of improvement has been faster in other countries than in the United States.

Analysis shows that the decline in infant mortality rates in Sweden in the past two decades has been due primarily to a decrease in deaths after the first week of life and also after the first month of life. While Sweden's rates are lower than any other country's, the pattern of decline is similar in many countries, including the United States, where a virtual plateau has been maintained since about the mid-1950's. But in Sweden the plateau has occurred at the low rate of approximately 13. It is made up of the rock-bottom etiological stumbling blocks to further reductions: congenital malformations, birth injuries, and respiratory disorders. These causes account for 50 percent of the infant deaths; unqualified immaturity accounts for 25 percent; and unknown causes for the remaining 25 percent. In Sweden, for low-birth-weight babies the perinatal mortality rate—fetal deaths and deaths in the first 28 days of life—is about 20 times that of normal-weight newborns.

Vigorous research and cooperation with other countries is necessary to uncover such common obstacles to improvement.

The U.S. picture

Now to look at the picture in the United States. The rate decreased from 100 in 1915 to 25 in 1965, with the greatest decrease occurring during the early part of the 20th century. Beginning in 1950, the decrease slowed considerably and the plateau appeared. Between 1955 and 1965, the infant mortality rate decreased by only 6 percent, or less than 1 percent per annum.[4] Between 1955 and 1960, only three of the largest cities in the United States had any reductions in infant mortality.[5]

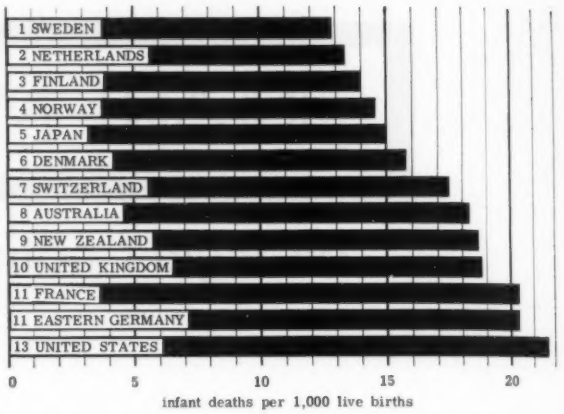
Of the 34 countries with rates below 50 in 1963 and 1964, the United States had the least favorable reduction during the preceding 5 years, with one exception.[2] The improvement, such as it was, seems to have been centered in urban areas.

Improved services in urban areas may be reflected in some reductions in rates. Urban rates have in recent years been coming down much more rapidly than in the Nation as a whole: reductions of deaths among black infants are greater than those among white infants.

Preliminary figures for 1968 are not encouraging; the rate of decline seems to have been somewhat under 2 percent as opposed to 5 percent in 1967. In the most important period of all, the first year of life, the risk of death is still higher than in all other periods before the age of 65.

It is important to eliminate once and for all an incorrect assumption drawn both here and abroad: that the major reason for the high infant mortality

INFANT MORTALITY IN COMPARABLE NATIONS
as reported to the United Nations in 1968



Source: United Nations Demographic Year Book, 1968. The rates represented are for 1967, except those for the following countries: Finland, New Zealand, United Kingdom, France, Eastern Germany, and the United States, which are for 1968; and the rate for Norway, which is for 1966.

rate in the United States is the well-known fact that the infant mortality rate among black babies is double that among white babies. The assumption is that the relationship of the black population with the poverty cycle is what is holding everything up and causing the problem. The assumption is inaccurate and misleading. Since only 15 percent of the U.S. population consists of black people, were that part of the population excluded from the rates, the U.S. infant mortality rate for 1967 would be only two points lower—20 instead of 22. There are, in fact, some indications that poor white families may have higher infant mortality rates, at least in some areas. Racial factors are the least of the problem as far as the overall high infant mortality rate is concerned. We have known for a long time that the death rate among low-birth-weight babies is especially high, but we are still not sure what factors contribute to this problem. The greater risks of death for low-birth-weight babies than for babies of normal weight are not limited to any one socioeconomic level. This points up the necessity to attack not only environmental, social, and economic problems associated with infant mortality but also the biological problems.

Some priorities

Modern, sophisticated biometric methods in some countries show promise of delineating two major groups of infants involved in infant mortality and approaches to a broad solution. The mortality rate needs to be reduced for babies of all birth weights, who can be considered as one group. But the most vulnerable group, babies of low birth weight, accounts for the largest part of the rate, which should have priority for reduction. This calls for concentration on the *prediction* of high-risk infants and the provision of special prenatal care and highly skilled care for mother and infant during the birth process and in the immediate postnatal period.

There is a vital need for many of the disciplines involved in providing health services to mothers and infants to work closely together to bring about significant improvements. The recent rise in standards of training and excellence in neonatology, that branch of pediatrics concerned with the newborn, should not give obstetricians the impression that the neonatologist can achieve success in the care of the newborn baby irrespective of the baby's condition or weight. All the factors involved in insuring optimal health of the mother during her childbearing years and especially during pregnancy are of the greatest importance, for they determine whether intact or damaged babies develop.

The macroscopic view of the problem obtained from the routine analysis of statistics is available for all to see. Much can be gained by more cogent anlysis, or the microscopic view obtained from the intensive study of individual infant deaths from representative samples.

Two key points must be stressed:

1. We need to concentrate not only on reducing infant mortality but even more on assuring that children who survive are whole and healthy. The often-forgotten morbidity of the saved, yet damaged child needs particular attention. Once an infant survives for a full year he escapes from ever being an infant mortality statistic. But is he intact? Is he healthy?

2. It is fallacious to argue about whether the quality of medical care or the child's environment is the more important factor in relation to infant mortality. These factors cannot be separated. No matter how good the medical care system is, mortality rates cannot be lowered below a certain point unless changes are made in the social environment, such as improvements in housing, income, and the quality of education available to the poor.

Some salient points

Both research and corrective action are needed to improve the chances for life and health for infants born in this country. Such improvement would inevitably show up in a reduction in our infant mortality rate. An effective plan of attack, however, will require attention to the following points:

- ***The irreducible minimum for the infant mortality rate is not known.*** In this country about 30 percent of

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Lively and healthy, this newborn has a life expectancy of 75.1 years. Nevertheless until she passes infancy she will be in the most dangerous period of life before the age of 65.

the babies who live at least a week but less than 1 year die of infections. This part of the infant mortality rate can clearly be reduced. But the greater part of the infant mortality rate is accounted for by infants who died during the first week of life, and therefore this is the part in which the principal reduction will have to be made. We do not know what the lowest possible rate may be nor how to achieve it.

● ***Deaths in the first week of life account for two-thirds of all infant deaths,*** according to 1966 figures.[4] That year, out of a total of 85,000 infants who died before they were 1 year old, 56,000 died within their first week of life. About two-thirds of deaths in the first week occur in babies with birth weights of 2,500 grams or less. Births of premature and low-birth-weight babies have *increased* about 8 percent in this country since 1950, when national statistics on birth weights first became available.[6,7]

Thus, the causes of low birth weight and short gestation period are fundamental issues in our infant mortality rate.

● ***The etiology of premature birth can be explored*** by looking not only at the quality and availability of health services, but also at the biological, social, and economic environment in which the baby is conceived and carried. The greatest efforts must be focused on the environmental factors that affect the baby's ability to survive his first week. This calls for vigorous examination of such factors as pregnancy intervals, age of mother, parity, the onset of labor, and the state of maternal nutrition—all factors in "maternal biology," to invent a phrase.

● ***The disadvantaged have higher infant mortality rates and a higher proportion of low-birth-weight babies*** than the population as a whole. However, there is a tremendous variance among different subgroups of the disadvantaged population. The problem is not tied to race. Infant mortality rates are different in different parts of the same city; adjacent counties in a single State have significantly different rates unrelated to race and socioeconomic background.[8] We need to discover what must be changed for each subgroup of the population, whether changes in the system of care will produce desirable results, or whether the total social and economic environment of such groups must be changed.

● ***The relief of social and economic disadvantages*** would have a major effect on infant mortality. Problems of poverty, nutrition (including promotion of breast feeding), sanitation, education, home and family conditions, and illegitimacy require concentrated attention. Organization of resources to deal with these problems can appreciably reduce the incidence of low birth weight, mortality, and morbidity among infants. Of all the factors involved, the nutrition of families is the one most amenable to immediate improvement, but a national commitment is required to attain this goal.

● ***Intervention to change a predictable and undesirable course of events can occur at many points*** over a long span of time, beginning as early as the childhood of the mother. Astonishingly little is known, however, about ways of controlling the factors in fetal and early childhood development or why specific factors have the effects they do. For many babies there is a brief critical period just after birth that can make the difference between life and death or between intact survival and a damaged child. The crucial need is to prevent such neonatal crises from occurring by insuring fetal excellence. Attention must be given not only to secondary prevention through highly skilled, intensive neonatal care, but also to primary prenatal prevention through highly skilled antenatal care, including when necessary intervention to avert a predictable event, such as the effects of RH incompatibility in mother and child.

● ***The effectiveness of various methods of intervention can only be evaluated by long-term studies*** that bridge the generations. While dramatic changes in infant mortality rates have occurred in areas where there are services providing comprehensive maternal and infant care and intensive neonatal care, such services may not represent the whole answer to the problem. Improved methods of caring for the fetus, for example, may yield even greater returns, particularly in terms of intact survival.

● ***Priorities for intervention have to be set, for resources are limited,*** even in a wealthy country. Two goals, however, are essential: (1) Bringing about changes in the social structure to eliminate underlying socioeconomic problems in infant mortality and morbidity—a long-range preventive goal; and (2) bringing about an immediate decrease in neonatal deaths and an increase in intact survival by making intensive obstetric and neonatal care available to all who need it. Infant mortality rates can be reduced rapidly by 40 to 60 percent in parts of the United States where they are lamentably high, through application of present knowledge and through the expansion of comprehensive maternal and child health services.

● ***Provision of staff to plan and carry out such services will require an extensive program of training.*** There is not only the need to train more people for health services and more types of health manpower, but also the need to train members of the overall health team in totally new ways.

● ***Family planning can have an indirect effect on infant mortality*** because it promotes and protects family health through better spacing of children. It can reduce the number of pregnancies among very young women (among whom the incidence of premature delivery is high), women beyond the peak childbearing years, those who are ill, and those who will be poor mothers because they do not wish to have children. The whole area of maternal biology as a backdrop to birth of intact, healthy newborns needs careful review and further investigation. Such investigation should include study of and attention to the female during the entire development age span before and throughout the childbearing years.

● ***All key factors involved in infant mortality contain elements in need of further research.*** Many of the recent reductions in infant mortality rates are directly attributable to the results of research on such problems as respiratory distress among newborns, asphyxiation, and RH-negative blood factors.[9] Similar work needs to be carried out in other areas—for example, the sudden infant death syndrome and the effect of malnutrition on fetal development.[10] Probably even more important is the need for controlled evaluative and epidemiological studies, using the microscopic, rather than the customary macroscopic, approach to determine the specific etiological factors in infant mortality and the effectiveness of various forms of biomedical intervention.

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INFANT MORTALITY TRENDS and MATERNAL and INFANT CARE

ELEANOR HUNT

Infant mortality is an important health indicator in the broad area of maternal and child health. Because of the frequent association between infant mortality rates and social factors, excessive rates may serve to identify neighborhoods and larger areas that have a high incidence of such social handicaps as overcrowded housing, limited education, high fertility, premature births, births out of wedlock, and other disadvantages. Estimates of trends in infant mortality rates during 1956–65 and in the subsequent period 1965–68, in the United States as a whole and in each State (except for Alaska and Hawaii but including the District of Columbia) have been made recently in a special maternal and child health study, supported by the Children's Bureau.[1]

When the States are grouped according to similarity of trends, a relationship appears between reduction in rates and the strengthening of services for maternal and infant care.

In the study the slope of the trend of the infant mortality rate was determined on the basis of the annual average percent change in rate.

During the decade 1956–65, the percent annual reduction in the U.S. infant mortality rate amounted to less than 1 percent (0.8 percent). In isolated semirural and rural counties where about 18 percent of all live births in the United States occur and the infant mortality rate is at least 10 percent above national average, the annual percent reduction in rate over the same decade was below national average: 0.6 percent in isolated semirural counties and still lower in the isolated rural counties.

The slow pace of reduction of infant mortality at the national level reflected lack of progress in many of the States. Of the 49 States studied 27 had essentially stationary rates in the sense that changes in rate during the decade could be explained on the basis of chance fluctuations. In the subsequent years, 1965–68, 14 of the same States continued to have mere fluctuations in rate without any significant trend (group A). In contrast, the remaining 13 of the 27 States recorded significant downward trends during 1965–68 despite their essentially stationary rates in the preceding decade (group B).

Of the 22 States that in 1956–65 made significant

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States Grouped According to Infant Mortality Trends 1956–65 and 1965–68

Group A:

Essentially stationary trends in both periods: Arkansas, Connecticut, District of Columbia, Illinois, Iowa, Montana, Nebraska, New Hampshire, Oregon, Rhode Island, South Dakota, Vermont, Wisconsin, Wyoming.

Group B:

Essentially stationary trends 1956–65 followed by significant annual percent reductions: Alabama, Delaware, Georgia, Idaho, Indiana, Louisiana, Mississippi, Missouri, New York, North Carolina, South Carolina, Tennessee, West Virginia.

Group C:

Significant percent reductions during 1956–65 not continued subsequently: Arizona, Colorado, Florida, Kansas, Kentucky, Maine, Massachusetts, Minnesota, Nevada, New Mexico, North Dakota, Oklahoma, Pennsylvania, Utah, Washington.

Group D:

Significant annual percent reductions in both periods: California, Maryland, Michigan, New Jersey, Ohio, Texas, Virginia.

progress in reduction of infant mortality, 15 failed to sustain a significant pace of reduction during 1965–68 (group C). The remaining seven States (group D) were characterized by a continuing downward trend in the infant mortality rates during 1956–65 and also during 1965–68, with a noteworthy increase in pace of reduction.

An increasing proportion of white infants among total births in the five States of group B was probably a factor in their accelerated decreases in infant mortality rates. States in this group that had an increasing proportion of white infants were Alabama, Georgia, Mississippi, North Carolina, and South Carolina.

An 0.8-percent reduction in the U.S. infant mortality rate during 1956–65 provides an estimated U.S. rate for 1970 of 23.7. However, based on the experience of 1965–68—which brought the rate for 1968 to 21.7—the estimated annual percent reduction has increased fivefold from 0.8 percent per year (1956–65) to 4.4 percent.

If the 1965–68 trend continues, the infant mortality rate in 1970 will be the lowest U.S. rate so far attained, 19.8. If the 4.4 percent per year reduction is sustained during 1969 and 1970, the lives of 25,653 infants will have been spared: 11,020 in 1969 and 14,633 in 1970.

Current provisional U.S. rates provide evidence of continuation of the more rapid rate of reduction beyond 1968. Table 1 shows provisional annual rates for 1965 through 1969 and the percent reduction in rate. Year to year percent decreases in rate are not directly comparable with an estimated slope of a trend over a period of years. Nevertheless, these annual decreases do illustrate that (1) in the United States infant mortality evidently declined more rapidly after 1965 than in the previous decade, and (2) on the basis of provisional figures, this pace of reduction has continued with some fluctuation through 1969.

Maternity care

Toward the close of the period 1956–65, maternity and infant care projects, financed up to 75 percent of cost by the Federal Government, were authorized by the 1963 Maternal and Child Health and Mental Retardation Planning Amendments to title V of the Social Security Act.[2] By 1968 there were more than 50 such projects operating in large- and medium-size cities as well as in rural areas. All of the projects have the same aims: improvement of maternal health and reduction of birth defects through high quality, com-

Table 1.—Provisional Infant Mortality Rates, United States, 1965–69

Year	Rate per 1,000 live births	Percent reduction from previous year
1965	24.8	----
1966	23.4	5.6
1967	22.1	5.6
1968	21.7	1.8
1969	20.7	4.6

Source of data: U.S. Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Center for Health Statistics, Monthly Vital Statistics Report. Provisional Statistics, vol. 18, no. 12, Mar. 12, 1970, and corresponding issues for preceding years.

Table 2.—Distribution of Maternity and Infant Care Projects, Fiscal Years 1965–68

State groups	Number of States	Number of projects	Number of projects	Average years in operation
	Total	Total	Per State	Per State
All groups	49	52	1.1	1.9
Group A	14	7	.5	1.4
Group C	15	17	1.1	1.7
Group B	13	18	1.4	2.0
Group D	7	10	1.4	3.0

Groups B and D, which have more projects per State than Groups A and C and whose projects have operated for longer periods, had the most noteworthy annual reductions in infant mortality rates since 1965. **(See chart p. 89.)**

prehensive maternity and infant care, including child-spacing services. The services are provided in areas with concentrations of low-income families, where fertility, prematurity, and infant deaths have high frequencies.

During fiscal years 1965–68, total annual expenditures of Federal, State, and local funds for special projects for maternal and infant care increased from $4,864,000 in fiscal year 1965 to $47,687,000 in fiscal year 1968. In the same years, but beginning as early as 1962, the federally aided State maternal and child health programs were notably strengthened.

Federal, State, and local expenditures per mother and infant for maternal and child health programs and for special maternity and infant care projects in the United States as a whole, considered jointly, and with allowance for increase in prices, amounted in fiscal year 1965 to $13.90 (constant dollars)—a 78 percent increase over the $7.82 spent per mother and child in fiscal 1956. In the 3 years following fiscal 1965 the expenditure in constant dollars per mother and infant rose more rapidly than in the preceding decade: from $13.90 in fiscal year 1965 to $19.45 in 1968—an additional increase of 71 percent in only 3 years.

Also during these 3 years neighborhood health centers, supported by the Office of Economic Opportunity, were established by local groups that reached out to find needy patients in deprived urban and other neighborhoods.[3]

In addition, Medicaid, established under title XIX of the Social Security Act, as amended in 1965, has provided medical assistance for the needy and medically indigent since 1966. About 25 percent of expenditures for medical assistance in fiscal year 1968 was for recipients eligible on the basis of membership in a family with dependent children under 21 years of age.[4] Figures showing how much obstetrical and pediatric care has been provided through Medicaid are not available.

Because of a lack of adequate data, at present it is not possible to tell whether or how much each source of service has affected the infant mortality rate. However, the distribution of special maternity and infant care projects among the four groups of States described does suggest that the presence of such projects in a State helped increase the annual percent reduction of the State's infant mortality rate during the period 1965–68. Groups B (13 States) and D (7 States), in which the States made the most noteworthy progress, were the groups that in those years had the largest number of projects per State. Moreover, at the close of fiscal year 1968, the projects in State groups B and D had been in operation longer on the average than those in groups A and C—2 and 3 years as compared with 1.4 and 1.7 years. (See table 2).

Nevertheless, even if the recent annual 4.4 percent reduction of infant mortality in the United States is continued, it is not adequate to achieve during the 1970's a national rate as low as that of Sweden's in 1967—12.9. To approach this level by 1975, the annual percent reduction in the U.S. rate needs to be accelerated to an estimated 7 percent.

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a preschool exchange . . .

black mothers speak and a white teacher listens

SYLVIA CLIFFORD KUNREUTHER

Recently public school educators have been forced to reexamine their relationships with local communities. Students and parents have complained that the traditional approaches—PTA, parent discussion groups, conferences—have not allowed for meaningful dialogue between school personnel and the families they serve. These problems are even more difficult in black communities, where white middle-class teachers and principals are not in tune with the customs of the people with whom they work.

For a teacher to be effective in her classroom, especially in a preschool, she needs a working relationship with the parents of children she serves. The teacher needs to understand that parents, after all, are their children's first teachers, and their approach to the teaching-learning process may be different from hers.

The attitudes that parents convey to their children in regard to school are greatly influenced by their own school experiences, which have often been experiences of failure. Too often the lack of communication between teachers and parents aggravates the parents' negative attitudes toward the school. But if the teachers communicate their concern, sensitivity, and questioning spirit to the parents, then the parents may transmit more positive feelings to the children.

In an effort to develop meaningful dialogue between the parents of some preschool children in a black inner-city neighborhood, eight mothers and I—their children's white preschool teacher—met weekly during the school year 1967–68. Tapes were made of the discussion sessions and through reviewing these, a clinical psychologist, James Hill, helped me understand what went on during the group process and my own role in it. The demonstration was part of a larger project to determine ways of sustaining children's interest in learning, being supported by the Kenneth F. Montgomery Charitable Foundation in collaboration with the Institute for Juvenile Research. What I shall call "the listening approach" was the major thrust of the parent-teacher program and the means by which the mothers and I grew to understand one another.

The Dr. Martin Luther King, Jr., Family Center (formerly Henry Horner Preschool) is situated in four contiguous apartments of a public housing development on the near west side of Chicago. All of the children served in its preschool live in this development. The eight mothers in the parent-teacher program were considered to have the most competent children in the total preschool enrollment of 40 children. They tended to have a better command of language than the average mother with children in

the preschool, although they did not differ in age, education, or income. Their children represented what staff members regarded as "typical 4-year-olds"—more mature emotionally, socially, and in the use of language than the other children in the center. This judgment was made on the basis of three independent observations: by a teacher in the classroom, by a social worker in the home setting, and by a psychiatrist in a play session.

The group

I explained to each of the mothers in the selected group that it was important for me to get to know her so that I could work more effectively with her child in the preschool. I told the mothers that I wanted to have weekly seminars for the entire school year as a part of my preschool program. All the mothers accepted the invitation and came regularly to the meetings, except one who had a full-time job.

We met every Tuesday around 10 a.m. for about an hour and a half in the center's parent and staff lounge, a pleasant room with comfortable, modern furniture. The mothers brought their younger children with them—sometimes as many as three or four—and babysitting services were provided. The preschool children were told that this was a special time "for the ladies." To create an atmosphere of informality, I served coffee or soft drinks to the mothers before the meetings.

In the first meeting I suggested that the mothers discuss whatever seemed most important to them at their sessions. For example, they might share ideas about child rearing, or comment on the preschool program. The unstructured format did not lend itself to continuity of ideas; a thread of continuity did emerge, however, in the emotional undercurrent of the meetings during the year.

This was the first time these black mothers and a white teacher had voluntarily spent any length of time listening to one another. I knew that the mothers were accustomed to white figures of authority who did not listen. My training had been in the traditional leadership role that connotes initiative, action, and control. Therefore, the experience was unique for all of us.

I was interested in learning about the mothers themselves—how they thought, how they viewed life, how they raised their children. I perceived my role primarily as that of a listener, which differed significantly from the usual one at parent-teacher meetings in which a teacher talks and parents listen. Sometimes I asked open-ended questions: "Why do you think Susie likes to chase the boys?" or "What do you think she means when she hits them?" At other times I served as adviser and counselor: "You can get help from legal aid for that problem." "Why don't you talk with Mrs. Brown about that?" My role, which might be accurately described as nonintrusive, soon became crucial to the success of the mothers' group.

The mothers quickly came to view the meetings as theirs—a time when a significant adult would listen to them. During the year, I became increasingly aware of the great value that they placed on my presence as a listener. Several incidents illustrated this. Once when I planned to attend a conference, the mothers voted not to meet. Later in the year when I told the mothers I would not be with them the following week, they decided to meet without me if the tape recorder were used so that I could later hear what they talked about. The mothers seemed to be saying that my listening role was essential to the functioning of the group.

The importance of my listening was brought home to me whenever I became actively involved in their discussions: the mothers ignored my remarks and even interrupted my comments. In this way they unintentionally helped me focus on my stated goal—to learn about them.

The mothers also gained a sense of strength from membership in the group. They took the initiative in leading discussions; they explored common concerns; and they became enthusiastic as they found they could express themselves and share their ideas for mutual profit.

Each week the same process took place: mothers vied for position and leadership in the group. One mother, who dominated the group in early meetings, was told later by the other mothers that she "talked too much." Another mother did not say a word for

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eight sessions; then she brought pictures of her family to show everyone. After that session the women felt comfortable enough to use first names, including mine. Some mothers didn't talk a great deal, but when they did talk, the other mothers listened carefully. Leadership shifted during the year so that at one time or another each mother was able to give direction to the group.

When Dr. Hill and I reviewed the tapes of the meetings, we noticed that an increased noise level often signaled the introduction of a new idea or the reaction to it. If all mothers wanted to talk at once, the issue had touched a common chord. Unlike my experience with white middle-class groups in which people tend to restrain their emotions, I found that these mothers expressed their feelings openly and the mood of the group could be determined quickly.

During the first few sessions, the newness of the experience made me anxious, but as I listened, I learned to value the open, honest, emotional expression of feelings.

Varied topics

The discussions were free wheeling and informal. They ranged from the sharing of mutual concerns to the planning for social action. Each week the mothers' discussions varied in subject matter as well as in emotional content. For example, one week they talked about the kinds of "motherly love" that mothers can give to their children. The next week they explored some problems of racial prejudice. The following week they considered the general problems of maintaining a household.

The topics discussed during the school year could be divided roughly into three categories. During the first 4 months the mothers complained about the conditions that caused them to be frustrated—raising children in the inner city, disagreeing with their neighbors, being poor, being black in a white society, encountering housing authorities, taking their children to clinics, and fearing for the safety of their lives, the lives of the children, and their belongings. In these first months I felt the mothers' primary feelings were anger, loneliness, and a sense of helplessness.

During the fifth and sixth months the atmosphere of the meetings shifted, becoming more supportive. The mothers, while still complaining of their frustrations, began to describe their own methods of dealing with problems. They spent some time comparing good buys on food and home appliances, making suggestions for trustworthy clinics or doctors, dealing with local housing authorities, and so forth. They tried to find solutions for each other's problems.

I sensed a growing feeling of trust within the group, as well as the emergence of meaningful friendships. The mothers talked of visiting one another on weekends, going to movies together, taking turns babysitting, and having lunch together after our meetings. This seemed a particularly noteworthy development for these mothers, who had previously avoided new friendships, although they had been seeing each other daily while bringing their children to the preschool.

The mothers acknowledged that families in a huge public housing project tend to distrust one another, thereby forfeiting the natural bond they might find through friendship. Their explanation made good sense to me: hostilities are bound to arise when too many families live close together in a place where they must share one common laundry room, one garbage disposal, insufficient elevators or dark stairways, and where they frequently find their mailboxes open or broken. There are 16,053 people living in the housing development, 143 families for each 14-story building, and an average of six children per family. The mothers had compromised their personal needs by limiting their close friendships within the housing project to one or two trustworthy people. They were taking a chance, they said, when they enlarged their circle of friends.

A change in focus

At the beginning of the seventh month, a definite change occurred within the discussion group. Several mothers showed their interest in solving problems that affected the world outside their immediate families. For example, one mother urged the others to attend a PTA meeting at the local public school; another mother said that she had been attending meetings of the building club concerned with day-to-day problems of tenants in the housing development. The group decided to invite a mother who was involved in community action programs to speak at a later meeting. One mother said, "If anything is going to be done in our community, we've got to do it."

The change in the group's focus began at a crucial period in this country's history. Just after President Johnson announced that he would not run for reelection, the mothers developed an interest in national affairs. This was soon displaced in favor of

more immediate concerns. Then the assassination of Martin Luther King, Jr., touched off serious rioting and fires in the business district only a block from the mothers' homes. There is no question that the events of April 1968 began a new era on Chicago's west side. This reconfirmed the mothers' decision to work for change in the community and in society.

During the last few months of the school year, the mothers agreed that "things are bad," and asked themselves what they could do. They said they were ready to take some responsibility for changing society. They began meeting outside the center, sometimes without me, and continued meeting periodically throughout the summer and the following school year. They became involved in activities to improve their own lives, the lives of their children, and those of other children as well. They attended school meetings, where they questioned teachers and administrators. Some took part-time jobs in community agencies, and others helped found groups dealing with specific problems. Several appeared on a panel discussion at a teachers' seminar to express their views on parent-teacher collaboration.

Personal concerns

The experience of the mothers in the group was different from what I had expected. I had thought the central focus would be the 4-year-old children who provided a natural bridge between us. However, the mothers did not raise questions about their children during the first seven meetings. In fact, they only discussed their children in four of the 25 sessions. At one point I tried to focus the discussion on the children, but this effort only inhibited the mothers in expressing their ideas.

When I asked the mothers what they wanted for their children, they became passive and waited to be called on. I decided to drop this type of questioning. Later without any prodding, the mothers spontaneously began to describe their goals for their children and to ask questions about aspects of child rearing. However, the mothers spent most of their time discussing the things that concerned them personally—where to shop, how to deal with their neighbors, whether attitudes toward black people were changing, and what to do about the numerous frightening experiences occurring around them such as rape, robbery, accidents, illness, and death.

The strength that these mothers gathered from the group enabled them by the end of the year to organize clubs within the various buildings of the housing project, to go to the housing management with their complaints, and to take a more active part in the local PTA. For the mothers, the group provided a community of concern, a place where they could express their feelings and frustrations knowing that they would gain the acceptance, assistance, and affection of other adults.

For me, the experience was an enriching one that helped me in understanding and becoming more sensitive to other people. It also gave me invaluable information about mothering, child-rearing practices, and parents' attitudes toward school and society that will be useful in my future relations with other parents. Moreover, it increased my understanding of the backgrounds of the children in the classroom, and so enabled me to plan with greater relevance to them.

The gap that often occurs between "what mother wants" and "what teacher wants" for the child became narrower because we had these sessions. I frequently found myself acting in collaboration with these mothers. The children became aware of this developing relationship, and they seemed to expect that their mothers and I would deal with school matters together. Indeed, they were right! When they felt they had done something wrong, the children would ask, "Are you going to tell my mommy?" They were less successful in playing parents and teachers against one another. Frequently during the year a mother would phone me to confirm something her child had said about school: "Did you tell Sam to bring his new truck to school, or is he making that up?"

Everyone involved directly or indirectly seemed to benefit from this program. After the mothers expressed themselves to others who were willing to listen, they exhibited more patience with their own children, seemed to listen more carefully to them, and seemed to be more receptive to their needs than before. I also got the impression that the mothers listened better to their husbands, although, of course, I cannot substantiate this with anything but a few clues. For example, toward the end of the year, one mother commented, "Men have feelings, too, I guess." The others nodded in agreement.

Within the group, all the mothers seemed to have increased their sensitivity to one another. The mothers also became more sensitive to the job that I, as a teacher, was trying to do with their children in the preschool. When they came to get their children, they began asking, "How did it go today?" Since I felt I could be honest with the mothers, I told them

exactly how the day had gone—even when it had not gone too well. Sometimes a mother would say, "I don't know how you can stand it with all these children all by yourself every day!"

In my previous experience at the nursery school the communication between teachers and parents had been seriously lacking. The parent-teacher collaboration made teaching more exciting, more enjoyable, and much more effective. As rapport developed between the mothers and myself, I was able to discuss with them my ideas of the kind of activities that might catch the children's interest in the center. I also felt freer to ask a mother something I needed to know about her child. When a mother and I were able to listen to each other, we could "tune in better to the needs of the child." Even the children seemed impressed with the parent-teacher collaboration. They would announce proudly to one another, "My mother talked to my teacher," or "My mother came for a meeting."

Parent involvement

The original plan called for one mother to work in the classroom every day to help me as well as to stimulate discussion among the mothers. This part of the plan never really succeeded. But the mothers' interest in what went on in the school did grow. By spring the mothers were selecting their own times to visit the classes. On several occasions when I had to be away from the classroom, the mothers took turns teaching. Whenever the mothers took total responsibility for a class, the project paid them for their services.

The children were proud to have their mothers become part of the teaching staff, although occasionally this puzzled them. One child, for example, asked, "If my mother is my teacher, then will you be my mother?" The children also commented on the various teaching styles of the mothers, as they had commented on my style. ("Mama, my teacher's white, but she's a lady just like you.") They recognized the special talents that the different mothers brought to the classroom. For example, they obviously knew that one mother had a good sense of humor and another was especially good at telling stories. Their observations of the mothers' different teaching styles stimulated the children's interest in their own and others' special skills. For example, one child would recognize another as someone who is good at building with blocks, someone who does puzzles well, or some one who makes good pictures. The children began to ask each other for help in developing these special skills.

Mothers who visited the class regularly observed the methods I used to foster learning and psychological growth. I would make clear to them my concern for the individual development of each child. On one occasion, for example, when a mother called the smallest boy in the class "a baby," I explained to her that I wanted the boy to see himself not as a baby, but as a 4-year-old with the same abilities as his larger classmates. After I enlisted this mother's help, she did a great deal to help the other children treat the boy as an equal. She began saying to the children, as I often had, "He can do it for himself. He's 4 years old, too." Later she commented to the other mothers about how much the child had progressed.

When the mothers visited the classroom for the first time, I used their comments about the children to open the way for our dialogue regarding children's behavior, what the children were learning in play, and how the activities could help them grow. The mothers picked up the ideas quickly and began looking for growth and change in the children and for meaning in the children's activities.

At the same time I learned to use the words and phrases that the mothers normally used when talking to children. This allowed me to converse with the children more easily. For example, when a mother said her child was "messin' around," she meant that he was disrupting the household, getting into things that didn't belong to him, and also that he was curious about his surroundings. Without abandoning good English, I tried to make the children comfortable by adopting some of the idioms familiar to them: "Don't mess with that!" "You're messin' around with Jimmy's things," and "Let's mess around with this fingerpaint."

One of the most productive discussions of children's behavior occurred after two mothers had worked in the classroom for a week while I was at a conference. The other members of the group regarded these mothers as strong personalities, and had chosen them to work with the children. Both mothers expressed strong opinions about their experience. One mother told the group she liked being with the children: "They didn't act as bad as you might think." She said she felt they were learning a lot.

The other mother said that she too enjoyed the teaching, but that she thought I was too permissive and let children get away with too much. She said disapprovingly that the children used "nasty" words,

had no manners, and played in water; she told about one child's hitting another. Her report sparked a lively discussion.

The mothers expressed concern about how children were disciplined and what controls were kept on children in the preschool, making it clear that they wanted their children to be "perfect." They asked me to explain what I was trying to do with the children, and what I expected to happen in the course of the year. They also questioned me about why children behave as they do, how children make adults feel, how the life they knew as children differed from life as it is for their children, and how the preschool staff handles various situations with children.

I explained some of the program goals and the relation of these to the mothers' complaints. The mothers listened attentively to my explanations about nasty words, manners, water play, and hitting. I had been permissive about the use of nasty words, I said, because I felt all 4-year-old children like to show their knowledge of nasty words. I agreed that the mothers had a legitimate complaint in this regard, and since this was an important issue for them, I promised to curtail the use of such words in the classroom. Some discussion ensued about how children learned these words in the first place. The mothers agreed that the children often heard them from their parents, but they still felt that the children's use of them should not be condoned. We also discussed each of the other issues that had arisen and reached agreement as to how they might be handled in the classroom.

This was a difficult session for me, but it opened the way for the collaborative approach that we followed for the remainder of the year. After this session, when these mothers had questions about the preschool program, they came to me; I explained my reasoning and listened as they expressed their points of view. Frequently in an individual conference a mother and I would discuss our differences in approach and goals. Through these joint efforts to learn what each of us wanted for the child's healthy growth, we were able to reach compromises that did not compromise good educational practices. Such experiences helped me sort out the essential from the nonessential in my teaching efforts.

Certainly, questions can be raised about the success of this demonstration in parent involvement at the Martin Luther King Center with mothers of high-functioning 4-year-olds. The demonstration was not scientific in the sense of collecting data to measure the effectiveness of the method used to establish understanding. Only the feelings and intuitions of those who were involved have been recorded.

Some questions

The questions remain:

"Did the children whose mothers participated in the discussion group in fact have a more productive year than they otherwise would have had?"

"Will the mothers who participated continue to take an active part in working with their children's teachers as the children progress in school?"

"Can teachers benefit from the intimate knowledge that a mother-teacher discussion group relationship affords?"

"Is the time spent in group meetings really worthwhile?"

While there are no positive answers, these questions must be considered in the light of current trends toward more community involvement in school programs. How these trends will ultimately affect learning is difficult to evaluate. But is there any other realistic course than to try new techniques in a situation that has been so poorly explored in the past?

Such questions need to be faced with an awareness that public education must change if teachers in preschools as well as those in elementary and secondary schools are to reach and teach all children in our society. Can schools and their teachers afford to remain isolated from their school communities or from the parents whose children they teach? There is a great need for teachers to risk the discomfort of new roles, in which criticism and compromise are inevitable. Persons in related service professions—social work, psychiatry, psychology—can help teachers develop the skill, confidence, and self-awareness to become educators in society rather than teachers of a few hundred children. Such role expansion can provide a powerful avenue to improve education for children and to facilitate personal growth for parents and teachers.

HELPING HOUSEPARENTS FIND AND USE THEIR CREATIVITY

HARRY E. GROB, JR.
ERIC E. VANDOREN

"Study time!" yelled the housefather to the teenage delinquent boys sitting in the cottage dayroom. Protesting mildly, the boys dragged up the stairs to their rooms. The housefather switched the television set to a cartoon program, sat back in his easy chair, and commented sadly to his visitor: "'Course the boys won't really get down to studying. Me—I had to quit school to work and I ain't ever been much."

According to correctional theory, this well-intentioned houseparent was supposed to be offering institutionalized boys an encouraging, creative life experience. He was an intelligent, honest person who had more or less drifted into correctional work. His qualifications included a certificate from an inservice training program, frequent reminders that houseparents were the "spokes of the institutional wheel," and an ability to get along with the other staff members, who called him "Pops." Although he had spent all his adult life in correctional work attempting to help young people, he had never been included in the planning and evaluation of the programs in which he worked. No wonder he felt worthless.

How differently he might have felt and how much more might he have helped the boys in his charge had he been encouraged to contribute his own ideas to the institution's program. This failure to encourage creative thinking from the persons in closest contact with the delinquents in care is a paradox in the correctional field.

When we, the writers of this article, assumed responsibility for the treatment program at the Chaddock Boys School, a private institution for juvenile delinquents in Quincy, Ill., we remembered this housefather and scores like him whom we had known in the past. We decided to find out what a small institution with a social work orientation could do to help houseparents become creative in their work and aware of their own value and creativity.

Our goal was to stimulate houseparents to express their real opinions of the treatment program and so enable them to put their worthwhile ideas into action.

We hoped they would also learn to face the problems of helping delinquents change, free themselves of immature in-fighting with other houseparents, distinguish between superficially "good" institutional practices and realistic, creative helpfulness, and realize dynamic fulfillment and relate it toward helping youngsters.

For 3½ years we offered all staff members at Chaddock—maintenance and professional staff as well as the houseparents—an opportunity to seek this goal

with us. We will here, however, confine our observations to the houseparents' response. We regarded staff members' participation in making decisions as elementary correctional group work. We realized, however, that houseparents who have always been told what to do will initially misuse opportunities to help devise a treatment program. They must first test the authorities to learn if they are to be listened to and treated with respect. In time, the houseparents recognize and use such opportunities properly and the youngsters in care begin to profit.

Busting loose

A list of rules, prepared and published by the administration, regulated cottage routine at Chaddock. Although houseparents said they complied fully, they often ignored the official rules because they resented having had no part in making the decisions. In practice they made their own rules and then quarreled about "different rules in each cottage."

We proposed that the houseparents meet with us each week to work out broad principles for a manual on cottage routine. More specific rules could be worked out by houseparents and boys in each cottage. At the meetings, each staff member would be equal—no one would "pull rank"—and each participant would rotate as discussion leader. All houseparents agreed to take part.

During the first months of our meetings, the houseparents did everything possible to defeat themselves. The discussion group was a new—and thus frightening—experience for them. Most of them, for example, acted like tyrants, especially when they were discussion leaders. Each leader attempted to bulldoze his own ideas through the group and discouraged discussion by the others. The leaders' comments indicated that they were also behaving like tyrants in the cottages—allowing practically no participation by boys in establishing cottage rules.

Some houseparents responded by testing the one acting as discussion leader. They would fall asleep in the meeting, whisper, tell jokes, stage tantrums, and "mob the leader"—"some of us got together last night and here are the rules we want."

The houseparents also tested us. Several times we let ourselves be baited into counterattacks. Our defensiveness took the form of silly lectures on being "fair" or "democratic." More often, with emotions under control, we pointed out that "all of us are trying to use our potential to be creative" and "all of us are trying to help the boys."

After the list of rules was completed, the houseparents decided to review them in a continuing series of meetings. Some houseparents said a review was needed because they had "pushed the rules way out" to test us. Others said that "rules ought to be changed to fit the particular times"—a belief we regarded as a move away from stagnation.

During the review, the houseparents showed a marked change in behavior. The leaders encouraged discussion without forcing their own ideas upon others. A more businesslike attitude prevailed, and many practical ideas were suggested. We told the houseparents that they had learned to be better discussion leaders than we were.

Toward the end of the review a housemother said, "When we started these meetings, part of the idea was to offer the boys the same experience that we are having in determining some of our own rules. I'm scared the boys will take advantage of this freedom."

Other houseparents expressed a similar fear, until a housefather changed the mood of the meeting by saying, "At first I took advantage of this kind of meeting myself but then I grew up. I think I can help the boys do the same."

To demonstrate his point, we conducted a number of group discussions with the boys, inviting the houseparents to attend as observers. These meetings encouraged the houseparents to support our efforts.[1, 2]

All the houseparents then began to meet with the boys in their cottages "as equals" to work out rules, using the rotating discussion-leader system. They were eager to talk to us about their experiences in these meetings. They told us how shocked they were to see many of their former patterns of behavior reflected in the behavior patterns of the boys. One housefather observed, "Bill bulls just like I used to do if the others don't agree with him." They were also impressed with the creative ideas that the youngsters expressed. A housemother remarked, "When you start being a human being with kids, you never want to go back to anything else."

Contributing to the paradox in institutional care are unspoken doubts about whether, in spite of honest efforts, anyone can *really* help delinquent youngsters change. Houseparents and professional persons alike seem susceptible to a kind of hopelessness. They may give lip service to the theory that delinquents can change but fail to act as if they really believe it. Those staff members who feel thwarted about being able to change constructively themselves tend to transfer negative feelings to the boys in their care.

Therefore, the houseparents in our group discus-

sions were openly encouraged to talk of their feelings of wanting to give up—"give-up-itis," we called it. They told us, "A person really wants to help these boys. You try to give them everything you've got. But most of the time, there's no change, not really. Sure, to get along with people and to keep your job, you say otherwise. Down deep, though, you give up after a while; you feel lonely just like these kids."

We suggested that together we "bust through your fatalism." The houseparents agreed to set up small committees to study the problems that depressed them. These committees operated without any interference from the institutional power structure.

Committee 1, for example, attacked the question, "How do we know a boy has really improved?" Its first report consisted of stereotyped answers. The staff rejected the report and asked the committee to look further into the question. The committee members channeled their angry feelings into action. They interviewed professional people in the local community—physicians, court officials, teachers, social workers, and others. They also asked blunt questions, through correspondence, of national experts in the fields of corrections and behavioral science.

The determination of committee 1 stimulated all of us to develop a positive, aggressive attitude in evaluating a boy's progress. Team meetings became opportunities to express doubts freely. The members of the staff complimented each other for objective, constructive statements regarding a boy's situation. However, a judgment of "no hope for this boy" always brought the question, "How do we know?"

At the end of the year, committee 1 made some observations—but gave no answers. In a final report, the chairman, a housefather, made these following points:

1. All of us have gotten a start in trying to figure how to judge a boy's progress.

2. We have learned that you have to study a boy when he comes here, stay close to him, talk over your concerns with him. You have to be able to talk to your coworkers about this boy without fighting and fussing.

3. The biggest thing we learned is about us. If you think you can change for the good, you'll think that most boys can too.

4. Look at yourself first, then look at the boys.

These committee assignments showed that, given the opportunity to be creative, houseparents can aggressively face the problem of bringing about constructive change—both in themselves and in delinquents.[3]

The houseparent-versus-professional-staff conflict is a senseless cancer that consumes creative energies in many institutions. Houseparents at Chaddock were spending too much energy in expressing hate for the professional staff members. In turn, the professional workers often displayed contempt for the houseparents. The houseparents were equipped with heavy artillery to do battle—they were acutely aware of the professional workers' shortcomings.

The boys were cognizant of the houseparents' feelings and had developed skill in further inflaming the situation. For example, when one of the writers of this article made his first visit to the institution, he introduced himself to a boy and asked for directions to the front office. The boy gave the information and walked toward a cottage where he was met by a housefather.

"Who's that?" the houseparent asked. The boy identified the visitor.

"Was he rough on you?" the houseparent demanded.

"Well, I guess not," said the boy.

The housefather exploded: "You act like he mistreated you. I bet he did. Those damn social workers!"

Dealing with conflict

Institutional administrators can support constructive efforts if they want to or they can encourage conflict by playing staff members against each other.[4] We therefore discussed the existence of such conflict with the institution's administrator, indicating our strategy for dealing with it. During the entire project, we were willing to discuss the remotest reference to staff conflict with anyone bringing it up. Our constant theme: Let people use their potentiality for creative activities so the boys can do the same.

From our past experiences as hospital ward attendants, houseparents, and professional correctional workers, we had learned that such conflict could be resolved through bold—even dramatic—thrusts by staff members working together as human beings. Furthermore, it would stay resolved unless an administrator or someone else stirred up emotions. We were forced to use our own imaginations in devising ways to solve the conflict, however, because the correctional field lacks literature giving practical advice on houseparent-professional staff problems.

At one of our first meetings with the houseparents, we appeared in casual clothing like that worn by the housefathers. Intentionally we began a rambling, theoretical discourse on program goals. This elicited

a furious verbal attack from the houseparents. We asked questions to encourage further expressions of opinion. Next we read excerpts from an article published in a professional journal relating to the solution of staff conflict. The houseparents grinned, giggled, and then laughed out loud. We joined in. Then we ended the meeting abruptly, saying above the laughter, "Let's talk some more later." This was also our answer to individual houseparents who asked why we laughed with them at "that college writing."

It was customary for housefathers to perform maintenance chores in the mornings while boys were in school. The next day after the meeting, we went out early to help with the cutting up of tree trunks. Intentionally we pushed ahead of the houseparents to do the dirtiest, hardest part of the work. We continued this pattern for more than a month.

During this time, we consulted in our office with individual houseparents about "boy problems" in a friendly, warm manner. We said nothing when they commented about our physicial labor. Housemothers began to tease their husbands, "Those fellows may be white-collar workers, but they sure can bust a log." Housefathers began coming to us individually, asking, "Can we talk about the trouble?," thus referring obliquely to the hostility they had exhibited to us as professional workers.

Nonchalantly we said, "Everybody can keep his job here, as long as he wants it, whether he hates us or not. Do we really talk or just patch up?"

The hostility of the houseparents toward us as professional staff members began to vanish when they realized that they could discuss openly with us anything they wished, when they discovered that we treated them as competent human beings, and when they involved themselves in constructive activities.[5] We continued to participate with the housefathers in physical work, explaining, "We all help in all parts of the program." Occasionally when under stress, individual houseparents regressed to displays of hostility. Then we said bluntly: "You can start using that old crutch or else face the problem like adults."

Hopes and dreams

After several months of group meetings, we reviewed staff development at Chaddock. Although we liked to think that we were helping the houseparents develop ways of releasing their creativity, deep down we knew that only a small impact had been made. We decided to review each houseparent's situation at the end of each day and offer suggestions for making better use of the houseparents' potential. These reviews were similar to the ones we had been conducting for the boys.[1]

When we told the houseparents of our plans, many of them envisioned a minute, fault-finding examination. They quickly recognized, however, that the reviews were more positive. Eventually the houseparents themselves began holding daily reviews with their colleagues, and later with the boys.

Our daily reviews disclosed many personal hopes and dreams of which we had been unaware. For example:

One housemother was threatening our confidence in ourselves. She was intelligent, honest, dedicated. We found her inquisitiveness, her eagerness to explain things, and her criticism of the program troublesome. Through conversation with her we learned that she had always wanted to be a teacher. At 63 years of age, she saw no hope of fulfilling her longing. Therefore we asked her to talk to the entire staff on the housemother's role in the treatment of delinquents. Later she taught a regular course in this subject for the staff and served as key instructor for new houseparents. She was also selected to work out procedures for encouraging the boys to greater achievement in school, procedures that were subsequently accepted by the staff. With little direction, she successfully applied her creativity to these tasks.

One housefather never seemed satisfied. His gripes about the program irritated us. In conversation, he told us of his dream to develop a new approach to the treatment of delinquent boys. At 50 years of age, with only an eighth-grade diploma, he was not interested in getting the necessary education to prepare for a program director's job. Yet he had the intelligence and skill to contribute materially to the institution's program. We encouraged him to mention his ideas for improvements, and these were accepted by the staff. For example, he formulated a new intake procedure for the institution.

Another housefather sent in a particularly well-written report. Our inquiries revealed that he dreamed of writing a book about institutions. We first encouraged him to write an article for a professional journal. After the article was published, we asked him to read some of the manuscript for his book in a staff meeting; the response was enthusiastic. Later while he was working in another institution, his book was published.

Creative environment

A creative environment in an institution for delinquents *could* be described in terms of well-meaning staff members racing about "doing good for others," inhibiting normal responses "for the cause of corrections," and, in the confusion, allowing the delinquent children to manipulate them. Social workers have often been charged with promoting just this type of chaos.

However, we found that when given opportunity to be creative, our houseparents began to give thought-

ful consideration to their actions. They also expressed their real feelings more freely than they had previously. And they were much less susceptible to manipulation by the boys. Flattery, attempts to incite staff member against staff member, and statements designed to arouse feelings of guilt had little effect upon houseparents who felt secure.

Boys, who knew they were accepted and believed in by the staff, did not need to deceive themselves with phony measures of progress.[6] They were relieved of the need to fool either themselves or the houseparents when they saw that the houseparents no longer needed to allay feelings of failure by pretending to see progress where none had been made.

Although Chaddock was a small institution, we feel that the principles we have described here can be applied in larger institutions. Larger institutions, however, may contain more roadblocks to creative expression. Their staffs may include uninterested persons, hired just to keep the positions filled. "Lost staff members mean lost youngsters," is the rationalization. But this "numbers game" breeds a sense of hopelessness in houseparents that they inevitably pass on to the youngsters.

We feel, however, that such road blocks can be dealt with by using approaches similar to those we used at Chaddock: the formation of creative problem-solving committees; the holding of section or department meetings built around staff ideas; the use, wherever possible, of ideas presented by staff members; and a sincere search for individual interests and talents that can be applied imaginatively in their work.

For example, one trend in large correctional facilities is to split the staff into small working groups,[7] called teams, blocks, units, or something similar. Working with segments of the institutional population, these groups function rather independently. This mode of operation provides staff members with support from each other and an opportunity to share information and ideas.

Reexamination

When the creativity of the houseparents at Chaddock reached a high peak, we asked, "Is this whole business—the program, staff democracy, a belief in troubled kids—a fraud?"

Several houseparents replied in the following vein: "At first we thought that you guys were trying to fool us, but not now."

"How can you be sure?" we asked. When the houseparents attempted to answer the question, we picked their answers apart. This puzzled them.

Harry E. Grob, Jr. (left), and Eric E. VanDoren report here on their experience with houseparents while working as program director and social worker, respectively, at the Chaddock Boys School in Quincy, Ill., a training school for juvenile delinquents. Both authors are now on the staff of the Illinois State Training School for Girls, Geneva, Ill., Mr. Grob as chief of social services and Mr. VanDoren as director of the Reception and Diagnostic Center for Girls.

We explained that sometimes an administrator offers houseparents a taste of creative opportunities and—unknown to them—purposely misuses whatever they achieve. We pointed out, as an example, that our group members were busy giving of themselves in helping boys, they trusted each other, and they were happy. It would be simple to deceive them by taking inappropriate advantage of their feelings of trust.

In a series of informal meetings to review the history of correctional institutions and the development of treatment programs, we emphasized the tendency of institutional staff members to follow fads. We showed how each major procedure at the institution might be rigged to appear helpful.

It took time for the houseparents to digest these elements of reality. At first they seemed to feel overwhelmed. Next came self-examination.

"I can see how a person just can't sit," a housemother remarked. "If you want a creative situation, you have to work for it, to think and speak up."

"There's another angle," a housefather said. "I saw myself in a lot of the things you guys said. Made me wonder how often I try to fool the boys, just for show."

Gradually, the houseparents became more aggressive in evaluating program procedures. They would not be rushed into making decisions; they became adept at asking, "How will this really help the boys?" For example:

The houseparents decided that all the boys should attend both Sunday school and church services in the community each Sunday because "those boys need to go to church and to be made to listen and get something out of it." They ignored the fact that most of the boys had never attended any church in their lives.

After a while, the houseparents began listening to the boys.

The boys said they disliked attending the church service because people stared at them and they were unable to follow the "boring" sermon. However, they did not mind attending Sunday school where they could participate in discussions with other teenagers, including girls. When several ministers supported this position, the houseparents agreed to change their rules.

Some mistakes

We made many mistakes in working with houseparents. Most of them were due to poor evaluation of creative expression.

Often we expected too much to be accomplished too fast. For example, we expected the houseparents to transfer their own creative experiences to the boys more quickly. Our frequent expressions of disappointment retarded the growth of some houseparents. We had to remind ourselves constantly that people who have been thwarted most of their lives cannot become creative overnight or immediately convey new attitudes to others.[8]

We sometimes substituted our own goals for those of the houseparents. Too often the hopes and dreams we remembered from our own days in subservient institutional positions crept through unconsciously. We wanted houseparents to have advantages that we had not enjoyed whether or not they were ready.

Our idea of having a staff library is an example. The houseparents responded positively to the idea and formed a library committee. We contributed money to the remodeling of a room and donated some of our own books. Then we noticed that most of the houseparents who used the library were only forcing themselves to do so. This attitude annoyed us until we realized that they were not really ready for a library and had only agreed to set it up out of kindness. Said a housefather: "I guess we figured you guys had a right to see some of your ideas in action; you've been fair with us."

A third mistake was in not recognizing that we could not help some houseparents through the group program. We were unsuccessful in keeping those houseparents in the group: (1) who preferred to be told exactly what to do instead of figuring out solutions to problems cooperatively, (2) who wanted us to check their performance by making surprise visits to the cottages, and (3) who enjoyed conflict for its own sake. Although we did not find ways to release the creative talents of such houseparents, we still believe it is possible to do so.

Another mistake we made was in not being consistent in responding to the houseparents' creative suggestions. We had invited the houseparents to speak freely and planned to react constructively to their ideas. But at times because of fatigue, personal worries, or discouragement, we unintentionally conveyed a sense of indifference by implying, "Don't bother us," and even, "Aren't you getting out of line?" We should at least have given an explanation such as, "You know I want your ideas. But this has been a bad day for me, so let's talk it over later. In the meantime, call me 'Old Grouch.' "

Even more regrettable, we occasionally questioned the motives behind a houseparent's suggestion. This error resulted in the loss from our program of several well-meaning but misunderstood houseparents. They had trusted our encouragement to be creative, but their ideas had frightened us, and we had rejected them.

Another mistake we made was to give in to the idea that uncreative adults can never help troubled youngsters. Houseparents tend to treat the young people in their charge in the way that they, themselves, are treated.

The Golden Rule might be paraphrased for administrative and professional staff in this way: "Do unto houseparents as you would have them do unto the kids."

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ONE PARENT ADOPTIONS

ETHEL BRANHAM

One of the axioms of our child-centered society is that every child needs a permanent home of his own. Yet some children are threatened with having to spend their childhood shifting from one temporary foster home to another because no permanent home can be found for them. Faced with a rising number of "hard-to-place" children, child-placing agencies have in recent years been expanding their resources for providing children with permanent homes, to include, among other couples, those who will provide long-term foster care, subsidized adoption, guardianship,[1] and adoption across racial lines.[2]

Another resource, less frequently tapped because it was long considered "outside the pale" of social agency policy, is the adult who has no marital partner but wishes to adopt a child. Only a few agencies have turned to this resource on the theory that a permanent home with but one parent, if carefully selected, can provide a homeless child with the security and love he needs. One of these is the Los Angeles County Department of Adoptions.

When the County of Los Angeles Department of Adoptions (then called the Bureau of Adoptions) was established in June 1949, it was charged with the special responsibility of finding adoptive homes for children who are difficult to place—children of minority racial groups or of mixed racial parentage and children with severe medical problems. The agency services were also offered to all mothers or expectant mothers who were considering relinquishing a child for adoption.

At that time in Los Angeles County, independent and black-market adoptions were prevalent, and the need for another adoption agency was plainly evident. Families wishing to adopt healthy babies of Caucasian background through licensed agencies usually waited several years before they received a child. Since the various adoption agencies had, on the average, about 10 suitable homes for each healthy white child, the rejection and dropout rates among applicants for children were high. Nevertheless, the child with special needs was usually overlooked. With so many prospective adoptive parents available, the new agency was optimistic about its ability to find homes for these overlooked children.

The intervening years have brought significant changes in the adoption picture. More healthy Caucasian babies are available for adoption, the waiting period between application and placement is shorter, and the qualifications for adoptive parenthood set by the agencies are related more to the applicant's ability to nurture an adopted child than to the scarcity of children. None of these changes has solved the difficulty of finding homes for children with special needs. Therefore the Department has supplanted its spotty and spasmodic recruitment efforts with an aggressive, full-time publicity program. It has also reconsidered a longtime policy of automatically rejecting lone adults as potential adoptive parents. Late in 1965, it began placing selected children for whom no other homes could be found with persons who had no marital partner in their home.

This practice became possible because that year the California State Department of Social Welfare revised its adoption regulations to allow acceptance of single persons as adoptive parents. The new policy clearly reiterated the established principle of adoption practice that *a two-parent family is the best of all possible choices for an adoptable child*, but it recognized the fact that two-parent families could not be found for all children needing the security of a permanent home.

In late 1965 the Los Angeles Department of Adoptions had registered with it more than 300 children available for adoption for whom adoptive couples were not readily available. This group included about 275 healthy Negro and part-Negro children of various ages,[3] 60 Mexican-American babies, 18 children of mixed racial background other than part

Negro, and several Caucasian, Negro, and Mexican-American children who had severe medical problems. When intensive efforts to find two-parent adoptive homes for these children failed, the Department decided to look into the possibility of finding them one-parent families.

The Department made its first one-parent placement in December 1965. At about the same time it launched a publicity campaign to make known its needs for adoptive parents, whether single or married, the first time any such campaign had invited single persons to apply. In the following 3 months it received 1,813 applications for children, the largest number in a comparable period since 1949. Most of the applicants were couples, but even so, the Department did not have enough suitable two-parent homes for all children with special needs. During the 2 years 1966 and 1967, the Department placed 40 children for adoption in homes with only one parent—approximately one-half of 1 percent of all the children placed by the Department for adoption during that period. They were placed with single women, divorcees, widows, and even a single man.

To learn what kind of parents these children acquired, the agency in 1969 reviewed the records of 36 of these 40 placements. Of the four children whose cases were eliminated from the review, two had been placed as the second adopted children of lone women; one, a school-age child, had been returned to the agency by the prospective adoptive parent; and one, an infant, had been removed from a questionable placement.

Parents' characteristics

In the 36 one-parent placements, 35 of the adoptive parents were women, 21 of whom were Negro; 10 were what is known in the Southwest as Anglo—Caucasian of non-Mexican background; and five were Mexican-American. The one man was a Negro.

These parents ranged in age at the time of placement from 30 to 54. Their educational backgrounds ranged from incomplete high school to achievement of postgraduate degrees. Half had at least some college work.

The review showed that the kinds of people likely to become lone adoptive parents are limited by self-selection as well as by the agency's selection standards. They seem to share many of the characteristics and life-styles of couples who adopt across racial lines. Marmor has described the latter as "people with a relatively high level of emotional maturity, high capacity for frustration tolerance, and an ability to pursue a relatively independent course in life, without being overly influenced about what other people think." [4]

These qualities stand out clearly in the descriptions in the agency records of the lone parents who have taken children for adoption. Moreover, the very fact that women with no husbands to give them financial and moral support are willing to form a family indicates that they are not greatly influenced by what other people might think. Their willingness to tackle the job of raising a child without the support of a husband suggests that they have a high degree of frustration tolerance. The adoption workers have described them as both self-aware and self-confident—strong enough to accept the likelihood of encounters with those who would imply that the adopted child was a child born out of wedlock and secure enough to handle the innuendo. For the most part they were well-organized systematic managers. They exhibited good intelligence, although some did not have a good education. They tended to be employed in jobs that gave them opportunities to deal with people rather than with things. Their lives included self-enhancing interests, hobbies, travel, and church or community involvement. Their motive for adoption was what they could do for a child rather than what the child could do for them.

"Vigor," "stamina," "patience," "understanding," "sensitivity," "sense of humor," "relaxed," "level-headed" appeared frequently in the records in describing these parents. For the most part, they seemed to have full lives, enjoyable occupations, and something to give a child.

The children

The children placed with these parents ranged in age at the time of placement from 3 months to 5 years.

Six children of mixed racial background—five Anglo-Negro, one Mexican-American-Negro—and 15 Negro children were placed with Negroes. These children ranged in age from 3 months to 5 years, but the majority, 15, were under 2 years of age. They included more than twice as many girls as boys, although both sexes were about equally represented among all the Negro children available for adoption. The preponderance of girls placed with lone Negro women reflected the women's requests.

Four of the children placed with Anglo women were of mixed racial background; three of them had

one Negro parent and one Anglo parent, and one had one East Indian parent and one Anglo parent. Of the six other children placed with Anglo women, two were Mexican-Americans for whom no other homes could be found, three had serious medical problems, and one had emotional problems. Eight of these children were less than 1 year old and the other two were under 4 years of age.

Of the five children placed with Mexican-American women, three were Mexican-American in heritage. The two others were placed with Mexican-American women because of their religion: both were born of Catholic mothers—one was a part-Negro child and the other, an Anglo child with bilateral club feet. The Mexican-American homes were chosen for the latter two children because they offered a Catholic upbringing. Three of the children placed with Mexican-Americans were less than a year old and the other two were under 2 years.

Most of the Mexican-American children placed with single parents were boys; two-parent homes are easier to find for Mexican-American girls, who are frequently accepted by Anglo couples.

Male companionship

The need for children, especially boys, to have a father figure to serve as a role model for sexual identification has been a major reason adoption agencies have avoided placing children in one-parent homes. But as Herzog and Sudia have observed, "children learn about maleness and femaleness from many sources, including adults in their homes, their peer group, TV, movies, and other mass media, and especially the persons—children or adults—who influence them particularly." [5]

The records show that the workers have paid special heed to the availability of male companionship for both the adoptive mother and the adopted child. Most of the 35 lone women with whom children were placed had close male relatives interested in the adopted child—fathers, brothers, sons, nephews, and, in a few instances, even former husbands. Thus the children had grandfathers, uncles, brothers, cousins, and adult male friends who could give them the kind of intimate contacts needed for male identification. Many of the women also had close male friends who took an interest in their plans for adoption and in the child after placement. In some instances the male friend had been interviewed during the adoption study and had been present when the child was first shown to the prospective adoptive mother.

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But even without male figures close to the family, children with an emotionally mature mother can be expected to develop an appropriate sexual identity. As Kadushin [6] has pointed out—

. . . the child in a single parent home has many secondary sources of identification through which to learn male behavior. Sex is working on our side in this matter. The boy possesses the observable, palpable, physical properties and attributes of a male (and) society expects him to behave as a boy. His mother, assuming she is reasonably normal, responds to the boy as to a male, approves of and encourages appropriate masculine behavior.

Two-thirds of the women had been married. This prior experience plus a yearning for the opposite sex, evident in all of the mothers, suggests that these single parents could compensate effectively for not having a man in the home. Most of them dated regularly. Many had interests and hobbies involving group activities that included both sexes. Men, both in and outside their families, seemed interested and willing to become father surrogates.

This proved to be true in the case of Mrs. O, who had been divorced after a marriage of many years. A 5-year-old boy was placed with her.

Mrs. O has three married children and six grandchildren. In spite of the divorce, her family is closely knit and all the members have welcomed the adopted child. Mrs. O has a large capacity for fun, patience, and understanding, and obviously enjoys children. A vigorous, self-assured person, she holds a professional civil service position and owns her own home. Although she was not interested in any man at the time of her divorce, she has since developed a close friendship with a man who is devoted to the child.

Placing a child for adoption with a mother who is over 50 is also a departure from traditional practice. The agency had already raised its age limitation for adoptive couples, first only with members of racial minorities and eventually across the board.

In approving homes of older single persons for adoption, the agency's workers were alert for elements that offered protection for the child's future as well as opportunities for normal development. This was so, for example, in choosing Mrs. D, a divorced Catholic woman, also in her early 50's, as an adoptive parent for a 7-month-old baby.

Mrs. D has a steady income and can well afford to support a child. Since she is no longer working she can give the baby full-time care. A 40-year-old man, a godchild of hers, has offered to sign any legal paper necessary to assume responsibility for the child in the event that something happens to Mrs. D. He lives across the street from her with his wife and five children.

In this case a family very close to the adoptive mother was readily available to take over if needed and also to provide the male models for helping the adopted child grow up to understand the difference in the social roles of the sexes.

Income and employment

The 36 lone adoptive parents had annual incomes ranging from $3,000 to $12,996 a year. All but six had yearly incomes of $5,000 or more and all but 13, incomes of $6,000 or more. Many, like Mrs. D and Mrs. O, owned their own homes. All but two were employed, and most of them had adequate health insurance and life insurance. A few had income from property or other investments. The two who were not employed had independent incomes and preferred to devote full time to the care of their children.

Two of the mothers had incomes as low as $3,000. Both, however, had good management ability, good prospects of improving their economic positions, and the emotional support and interest of close relatives or friends. One of these women, for example, was a young widow, Mrs. N, who was chosen to be the adoptive parent for a 5-month-old girl.

Mrs. N works on an assembly line from 4:30 p.m. to 1 a.m. These hours allow her to be with the child most of the day. Mrs. N's sister and her family live next door to her and take care of the child while Mrs. N is at work.

Mrs. N is the sixth child of a large, closely knit family. All but one of her brothers and sisters live in Los Angeles County, as do both her parents. She also has 18 nieces and nephews, 15 of them children and three adults. Before the adoption, Mrs. N was the only childless member of her sibling group. Cooperation is a well-ingrained characteristic of this family. Mrs. N's sister, from whom she rents, lowered Mrs. N's already low rent to help her support the child.

Mrs. N manages well. She owns a car, which is fully paid for—as is all her furniture. She carries adequate life insurance and enough health insurance to cover medical expenses for herself and her child. She has completed a course as a grocery checker, which she expects will help her obtain employment with a better salary. Moreover, she may eventually have the support of a husband, for she is a handsome, warm, cheerful woman who gets along well with men.

Placing children for adoption with women who are employed full time is another break with traditional adoption practice. But today the working mother is commonplace. The agency has therefore not regarded such employment as a sufficient reason for keeping a warm, emotionally stable woman from becoming a parent of a child desperately in need of a home of his own. It does, of course, look into the adoptive applicant's plan for providing child care while she is at work.

The records show that all the working adoptive parents took a leave of absence at the time they received the child, the majority for at least a month and only five for as little as a week. Nearly a third of these mothers had relatives or housekeepers living in their homes or next door who cared for the child in the mother's absence. The rest had arranged for child care in the homes of relatives, licensed day-care facilities, and nursery schools during their working hours. Three worked only part time and so could spend most of their time with their children.

Attitudes toward children

Almost without exception these lone adults had had rather deep relationships with children before ap-

The happiness on the face of this child reflects the security of a home of his own in an atmosphere of tender loving care. Such an atmosphere can be provided in an adoptive home, even when there is only one parent, some social agencies believe.

plying for a child to adopt—either through their own families or through their employment. Eight of the women had raised other children—born to them or adopted—before applying to the department for a child. The one man with whom a child was placed had previously had sole responsibility for 3 years for the support and care of two young nephews. One of very few male applicants for a child, he came to the agency after his nephews' mother had found herself in a position to take her children home with her.

Mr. R was the youngest of a large group of brothers and sisters, who had helped their mother keep the home together after their father deserted the family. He had matured into a relaxed but meticulous and sincere person. He wanted to adopt a child not only because he missed his two nephews but also because he wanted to help a child grow up with less of a struggle than he had had.

A 4-year-old boy was placed with Mr. R. He made a home just for the child and himself for 3 months so that they could get to know one another without other distractions. During this period he employed a part-time housekeeper, who came to the house early to prepare breakfast and take the child to nursery school. He even bought a car for the housekeeper's use. Later Mr. R and his son moved in with his mother, who assumed the responsibility of household management while Mr. R took over the task of taking his son to nursery school.

Mr. R spends a great deal of his leisure time in church activities. Through these he has met a woman whose company he enjoys and who he hopes will soon become the child's mother.

Because Mr. R and the 35 women without husbands to help them each took a child for adoption, 36 children who otherwise might never had achieved a feeling of permanence now have families of their own. Admittedly these families are incomplete, but they are "for keeps." Only with some assurance of permanence can a child develop a basic sense of trust.

Undoubtedly the incompleteness of a one-parent home presents some difficulties for the parent and the child. But these difficulties need not be regarded as insurmountable obstacles to healthy child development. They can be compensated for to a large degree by support from the parent's relatives and friends and by other persons in the community.

Evaluation planned

The Los Angeles County Department of Adoptions has shown that many persons without marital partners do have a great deal to offer children and that they will do so when given an opportunity. The review of these 36 case records strongly suggests that the children involved have found true "familiness." It does not tell us, of course, anything about how the children are responding to the experience. Only time can tell—time for the children to grow up and for the agency to make a careful evaluation of their adjustment at periodic intervals.

The Department is now planning such a longitudinal study. When completed it could have important implications not only for adoption policy but also for an understanding of the strengths and weaknesses of one-parent families of all types.

At the present time, the Department is making fewer one-parent placements than it did a few years ago because more couples are applying for children to adopt. More couples are asking for Negro children, although not yet enough to take care of all the Negro children needing adoption. The supply of families for other hard-to-place children fluctuates.

The one-parent home is just one resource for helping to close the gap between available hard-to-place children and adoptive families. Communities committed to the welfare of their children will explore every feasible plan for providing children with adequate permanent care. The best plan for one child with special needs may be a single person who is especially qualified to meet those needs. A better plan for another child, who feels secure with his foster parents, may be to encourage the foster parents to keep the child on an agreed upon permanent basis or to grant them a subsidy so that they can afford to adopt the child. When the luxury of choice is available, the placement worker can think through the alternatives so as to best meet the needs of the child to be served.

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A SERVICE PATTERN FOR HELPING UNMARRIED PREGNANT TEENAGERS

RUTH R. MIDDLEMAN

In this article I shall try to make the case, theoretically and illustratively, that really helping the unmarried pregnant teenager calls for dramatic, innovative service patterns and relationships that have a forceful impact. I make no claim that my thinking has been put to the test of research. Rather, it springs from my own work and the work of my social work students over several years in trying to help pregnant teenagers.[1, 2]

My two central themes are: (1) work, and (2) meaningful communication. I shall discuss *work*, not in the usual sense of employment but as a vital dynamic in the pregnant teenager's search for relatedness to others, to things, and to the continuity of her own life. I shall discuss *communication* as the avenue through which others may help her achieve this relatedness. Although these two themes could be explored or examined separately, I will show how they merge and interact with one another as the helping process unfolds. The helping relationship evolves through the work and the work evolves through the helping relationship.

What then are the major tasks of the unmarried pregnant teenager? Erik Erikson, in his theory that everyone encounters a series of eight developmental crises in the course of growth from infancy through old age,[3] provides a clue. For example, he has described the crisis of adolescence as establishing one's own *identity;* the crisis of young adulthood as developing *intimacy* in relationships; and the crisis of adulthood as *generativity*, or creating and nurturing new life. At each period of life the human being must resolve the developmental crisis through mastering certain tasks.[3, 4]

The teenager faces what is perhaps the most tormenting crisis of all—the establishment of identity. Who am I? What am I like? What will I become? What will become of me? These questions plague every teenager. The unmarried pregnant teenager is no exception. She is first and foremost a teenager—hard as this fact is for some adults to remember as they see her body bulging with new life.

While she shares the identity crisis with other teenagers, the pregnant teenager also has plunged herself—at least physically—into the demands of adulthood. She has one foot mired in what Erikson calls the identity crisis and the other foot in the crisis of generativity. In between is the vast terrain of the crisis of intimacy which she has not touched.

The unmarried pregnant teenager must achieve some sense of her own identity so that she can—if she so chooses—become a mother to her child. She needs to make concrete plans for the range of realities that mothering entails. Beyond this, the unmarried pregnant girl desperately needs to back up and reenter the developmental continuum at the point where she left off. This means reaffirming her identity and then moving on to experience the real intimacy of young adulthood. Only then might her second encounter with generativity be a satisfying adult experience.

Thus the pregnant teenager has a lot of work to do. All too often she doesn't even know it. Furthermore, the changes in her physical self and social status drive her into isolation.

As part of a study of black, pregnant teenagers in a hospital's outpatient clinic, I selected eight who were pregnant for the first time to participate in a group experience. I found them frightened and resistant in response to the unplanned birth. A wide range of forces pressed upon them. They brought fears about the bodily changes of pregnancy and the unknown birth process. They feared physical pain. They also feared the hospital and its many unfamiliar procedures and people.

Many of the girls felt isolated from their boyfriends. Many felt guilty because they had not lived up to their mothers' hopes that their daughters would somehow be different from themselves. All of them

were reluctant to look at the social aspects, the nonphysiological part of their situation. They had come to the clinic for medical supervision of their pregnancy.

At my first group meeting, I found these pregnant teenagers guarded and resistant, full of "yeses" and silences. They seemed willing to listen to what I wished to say but not willing to become involved themselves. Because they were black, I wondered whether their reluctance came from the fact that I was white.

Subsequently, I learned that Gola Tatum, a black social worker, faced the same problem of resistance in attempting to initiate a combination of individual and group social services for black pregnant teenagers in a community health center. When she met with a continuing education class of 16 girls ranging from 12 to 17 years of age, she found:

> **There was no conversing among the girls and muted munching of sandwiches and aimless shifting of book pages, and heads hung down and eyes dropped. The girls seemed to have made a solitary confinement of the classroom . . . .**

Mrs. Tatum returned the next week to help the group plan a Christmas party. Again, the girls' remoteness and resistance were obvious:

> **They were hesitant about speaking out and continuously looked back and forth at each other and dropped their heads. It took 15 minutes to vigorously twist out the first suggestion. Another 20 minutes passed before they reluctantly completed the plans for their Christmas party. By the end of our discussion, the girls appeared guardedly excited about the coming event.**

Perhaps the fact that neither Mrs. Tatum's group nor mine welcomed the social worker suggests the need for a different way of reaching out to pregnant teenagers.

In my work at the clinic, I have tried to avoid beginning stalemates by using an approach that I feel is more congenial to an interchange between the unmarried pregnant girls and myself. At each meeting I introduce a task for them to work on—a task that is explicitly related to their engagement with each other and with me in the context of the hospital at one particular point in time. Helen H. Perlman has written of the underlying values of school work in the same sense in which I see the value of group tasks:

> **School work provides the child's first experiences of required self-discipline in line with a planned and regularized program and sequence of tasks, of putting himself into doing things with his eyes and ears and head and hands. If these are well done, they give him a sense of knowing and mastery and accomplishment. If unhappily he cannot "do the work," for whatever reasons, he is left feeling inept, discouraged, and socially shamed.[5]**

I have found that if the group activities can begin around a means of communication less threatening than words—that is, if the initial task is related to the previous experience or current interest of the participants—then communication can occur with less anxiety and group members will speak with less self-consciousness.

For the series of weekly meetings I selected a sequence of tasks, one for each session, through which my helping relationship with my group would develop. I tried to convey nonverbally my expectation that the girls would express their feelings, attitudes, values, and conflicts as they performed each task.

The first task was to take action about the physical changes of pregnancy. Upon meeting the girls I asked them to change out of their good clothes into green surgeons' gowns. Playing soul music as a background, I then showed them simple exercises—originally developed by physicians and nurses—that are helpful for relaxation during pregnancy and delivery.

I deliberately adapted the movements to involve the members of the group with each other in pairs. My purpose was to develop, through action, a supportive group culture. The participants held hands. helped each other with balance, and watched their partners' progress. As they began doing the exercises, they usually began to talk with each other and then with me. They talked about how well they were doing the exercises, whether and where they could do them at home, and how often they could do them. After this experience, it was easy for them to begin to talk during a sitting-down time about what they were eating, how they might be able to watch their weight and why they should, how they could eat and do their best in other ways for the baby growing inside them. They seemed very much interested in talking about caring for themselves rather than only thinking about the baby or their "problem."

In the second session the following week I began with questions about how their exercises were going. I found again that the girls did not have much inclination to talk. I then presented another simple task: I asked them to draw a map. ***My objective was to help them see the connection between themselves, the hospital, and their present situation.*** I asked them to show in one corner of the picture the building in which they lived, to put the hospital at the corner

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across the page, and to show in between how they came from their neighborhoods to the hospital.

After they finished their maps, I asked them to talk to each other in groups of two or three to find out more about each other—for example, Who comes to the hospital on the subway? Who lives farthest away? I found that the concreteness of this experience brought something familiar to an unfamiliar situation. At least the girls felt in control of what they were to do in regard to this piece of work.

After the first mapmaking I asked them to make other maps having to do with their present experience together—for example, a map of the first floor of the hospital with various hospital workers on it, or a map of a baby's room. At some time during this mapmaking (which I was careful not to call "drawing" or "art"), their questions, worries, opinions, and feelings began to come out. We then dispensed with the mapmaking and focused our attention on discussion. The initiative for the questions rested with the teenagers, who were quick to seize the opportunity to explore their concerns.

Events in the second session of the group illustrate the impact of such a mapmaking experience on the girls. Five members of the group, two girlfriends (not pregnant) of one of them who had come along to provide support, and a 4-year-old boy for whom one of the girls was babysitter, were there. With only a little encouragement from me, all the pregnant girls became involved in the mapmaking. The verbal interchange between one girl, Jean, and myself sparked participation by all the girls in an important discussion that grew out of and—to my delight—eclipsed the drawing experience.

On one page Jean drew a picture of her neighborhood. She showed her apartment with its street number. Next door was a large store with a "Rummage Sale" sign in the window.

In the store were stacks of used books marked 10 to 25 cents and a dress on a manikin. In addition, this picture included a bus passing the "White Doom Tower" and two autos. At the bus stop waited Jean—her belly visibly round—and her two girlfriends, looking very trim, who had come to the meeting with her. At the top of the page was an arrow with the words, "over for hospital." On the back of the page was depicted the entrance of the hospital with two tall doors, and "me entering" above a walking figure.

Jean talked about these pictures as she drew them, directing her remarks to me. She asked whether she should put down her due dates "Aug.-Sept. 30," and I encouraged her to do this. Suddenly realizing that she would have a different profile then, she set about erasing and changing her drawing, saying, "I'll need bigger breasts then and a different shaped belly." The whole group was watching, listening, and giggling, as Jean proudly waved the changed picture about and admired her own work. The group members then moved spontaneously into a discussion of many issues that concerned them.

They asked the following questions: Who else is due when I am? Will we meet at the front door of the hospital? (Laughter.) Can we be roommates? What kind of a room will we be in? How many people will be in the room? Can our boyfriends visit us? Can we have many visitors? Can anyone else watch the birth of the baby? Are you alone when you are in labor? Is it true that you are paralyzed from the waist down with a needle? What kind of way do they put you to sleep? Are you knocked out when the baby comes or do you see him? Are you on your stomach or back?

I responded to these questions according to their manifest content, answering them simply and correcting misinformation when necessary. At the same time I was careful not to deride the folk myths the teenagers had learned from their mothers. For example, after several girls said they had been told that fright would disfigure the unborn child, we discussed the question of whether or not they should watch a "scary movie" during pregnancy.

Many of the teenagers' questions concerned the physical pain of childbirth and their fear of it. One, worried that "all my insides will be taken out," wanted to know when this would be necessary.

At this meeting we made arrangements to take a trip together later through the maternity floor so that each member of the group would be familiar with her surroundings when she entered the hospital.

In our discusssions I tried to stick closely to the concerns the girls voiced. Mainly, I tried to convey a feeling of comfort about the naturalness of their

questions, encouragement to talk about the worries that they had not mentioned before, readiness to hear their fears, and an openness to think about facts rather than hearsay. As these young expectant teenagers grew more free to discuss their concerns in the group, they also became more free to raise questions with their physicians.

I maintained my concrete approach through subsequent meetings. At one point, I introduced a board game called "Baby's Coming," which I designed to focus attention on the problem of unwed motherhood. The game deals with the range of issues set in motion by the pregnancy of an unmarried teenager. Because this content is very serious, I conceive of the game as work. ***The task the game demands is that of facing up to life.***

Playing a game

"Baby's Coming" simulates the interconnection of all the people who became involved with each other because of the pregnancy of an unmarried teenager—the pregnant teenager herself, the unmarried father of her expected child, the pregnant teenager's mother, the social worker, and the doctor. Each participant in the game chooses a role to play; the most popular roles are "unmarried mother," "unmarried father," and "your mother." The players take turns throwing the dice to determine their moves on the board. When a player lands on a spot, she encounters a situation that is a piece of the problem. She must read the situation card aloud, and then must choose a response. For example, at the first spot the teenager's mother is presented with the situation: "You think your daughter is pregnant." The five possible responses are scored as follows: "You are not surprised; you've expected this" (−5); "You don't sleep as well at night," (+1); "You watch her more closely, including her personal habits," (+5); "You pretend you're imagining this," (−1); "You ask her if she is," (+10). Each choice contains a statement elaborating the consequences. For example, if the player selects "You ask her if she is," the statement is "This is facing things squarely."

As the movement through the game progresses, the consequences of each choice determines the player's progress toward winning. Through the activity of the different players, all the players can see their situation objectified in a simulated experience rather than hear it discussed by an adult authority, however sympathetically that adult may present the issue. I have found that pregnant teenagers try to pick out what they believe is the "right" thing to do, not necessarily what they *would* do. But I am not troubled if they figure out how to "con" the game, for meanwhile they are learning that such actions as staying in school, planning ahead, or considering others are rewarding types of behavior.

Communication

These exercises, mapmaking, and games, then, are the tasks I have used to bridge the communication barriers that, all too often, separate the would-be helper from the person seeking help. My view of work is a many-faceted one. It includes a concept of work as the focal point for the communication between the helper and the one being helped. When the communication is focused on a task, the unmarried pregnant girl comes face to face with her situation, and tries to deal with it, however reluctantly. The work for the helper is to become engaged with the girl in this effort, offering her support in such a way that she will want to work on the issues surrounding her pregnancy. Perlman has described the work-dynamic for man:

> **Work should provide not simply the means by which man earns his daily bread but also the means by which he can express, nurture, and find himself . . . . the involvement of the child in actions that make some impression upon others or objects—these, when they yield to his effort, are his proofs of mastery. This is how the child—and later the man—knows his strength.**[5]

Elsewhere I have discussed the similarity in dynamics between the concepts of work and play.[6] Often the main difference lies in how a person feels about what he is doing: for some, playing can be work; for others, working can be like play. In the group I have described, work seems to have become more engrossing for the members because the initial tasks were simplified and made relatively comfortable for them. The basic work—action-oriented tasks related to the central problem of pregnancy out of wedlock—led to effective verbal communication.

Thus, the work itself was the form of communication—both nonverbal and verbal—in the group sessions described. By moving from nonverbal to verbal methods, the girls were able to communicate with me more quickly. Mrs. Tatum has confirmed this point in describing her experience in the community health program:

> **The film I had planned to show at this first meeting could not be shown. I walked around contemplating for about**

5 minutes what I could do to get a nontalking, unresponsive group of timid, ashamed, unmarried pregnant teenage girls to forget momentarily or relax and act like other teenage girls. I immediately went into a brief discussion on verbal and nonverbal communication, and how this was important to our relationship and getting to know each other.

I asked for three reluctant volunteers to do a skit in which a daughter asks a mother and father for money for a new party dress. This broke the ice, and the girls were slowly on their way toward partial participation. I acted out a shopping skit with another girl, using "vegetables" to show the importance and influence of nonverbal communication [through facial expression, gestures, tone, and pattern of emphasis] and this "cracked them up."

I requested that each girl move her chair away from her table and form a semicircle, because most of them appeared to be holding onto their chairs for life. They were then asked to play tic-tac-toe using nine girls' names and finding out two things about these girls. It was amazing that many girls had been going to class together for months and had never met each other. All of the girls were completely involved with each other, laughing and talking, acting alive and young . . .

I believe all persons who offer services to others—especially middle-class persons—need to reconsider the blockages in communication inherent in their verbal emphasis. In addition to being skilled in picking up the nonverbal clues to the clients' feelings—posture, pauses, body movements, tone, and so forth—the helper must learn how to make the most of his own nonverbal methods of communicating to the clients. He must reach out on many congruent levels at the same time if he wishes to be understood and be perceived as a person who really cares. This need to communicate at many levels holds true for all types of exchanges—even among persons of similar backgrounds—staff interactions, for example.

Stuart Chase long ago emphasized how incongruities and resultant misunderstandings can becloud one's meaning in verbal exchanges.[7] The dilemma is heightened when the exchange is between persons of different socioeconomic classes, whose vocabularies may include many words with meanings outside the experience of the listener.

A recent study on the communication of emotions and meanings shows that even when the words used are clearly understood by both parties, the verbal part of a spoken message has little effect on whether a listener feels liked or disliked.[8] The verbal content of communication accounts only for 7 percent of the total effect. The balance of the meaning is conveyed facially—55 percent—and vocally by intonation, tone, stress, length, and frequency of pauses—38 percent. An exclusively verbal approach thus becomes a serious limitation for social workers, teachers, doctors, nurses, and others.[9]

My activities in serving groups of pregnant teenage girls encourage me to believe that through the wider use of the methods I have described, many grave problems might be faced more squarely by persons who are uncomfortable and reticent in a one-to-one interview or in a strictly verbal group discussion. My major focus is on concrete tasks—activities especially tailored to involve the skills, understanding, and previous experiences of the person being helped. But these tasks are only a point of departure in the communication process. Once the human connection is made, I find that the problem of verbalization is less of a barrier to meaningful exchange.

A concept of work was introduced at the outset of this article by my reference to Erikson's developmental crisis. In this frame of reference, "work"—that is, mastering the tasks involved in resolving the crises—is the problem situation around which the helping process forms.

Even Freud, when asked what he thought a normal person should be able to do well, replied simply, "Lieben und arbeiten" (to love and to work).[10]

Those of us who are engaged in service to others have, I believe, paid much attention to the love part of Freud's formula and far too little to the work part. Work, in the broad sense presented here, is a powerful means offered to those seeking help: through work they can discover their capacities, display their powers, and gain some sense of their limitations.

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THE RIGHTS OF FOSTER PARENTS

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In recent years there has been a growing movement among foster parents to form their own organizations, usually with the help and often at the instigation of the social agencies that place children with them. These organizations have a dual purpose: (1) To discuss the common problems of caring for other people's children; and (2) to raise the status of foster parents as carriers of one of the three major roles in foster care, the other two being the roles of the placement agency and the child's own parents. Increasingly such organizations have been focusing attention on foster parents' legal and moral rights and responsibilities.

What are the rights of foster parents? We present here, with no implications of priority, a tentative list and are inviting the readers of CHILDREN to submit additions or revisions in preparation for a forthcoming National Conference of Foster Parents to be sponsored by the Children's Bureau, Office of Child Development, October, 1970. As presented, it incorporates many of the points made by Judith Gordon, child welfare supervisor for the San Francisco Department of Social Services, at a foster parents' institute convened by the Foster Parents United Association of San Francisco, October 18, 1969, and by George Goldmark, foster home developer in the same department, in reporting on the institute.

Foster parents' rights

Foster parents have a right to—

1. *A clear understanding of their role as foster parents* and the roles of the natural parents and the placement agency in respect to the child in care.

2. *Respect, consideration, trust, and valuation* as an agency employee or volunteer who is making an important contribution to the agency's objectives.

3. *Involvement in all the agency's crucial decisions regarding the foster child,* as team members who have pertinent information based on their day-to-day knowledge of the children in care.

4. *Freedom from built-in failure,* through not being asked to care for a child whose needs they cannot meet.

5. *Continuation* of their own family patterns and routines.

6. *Support from the social worker* in efforts to do a better day-to-day job in caring for the child and in working to achieve the agency's objectives for the child and his family, through provisions of—

a. *Pertinent information about the child and his family.*

b. *Help in using appropriate resources* to meet the child's needs.

c. *Direct interviews between the social worker and the child,* previously discussed and understood by the foster parents.

d. *Consultation regarding specific problems of the child.*

e. *Information regarding the child's progress after he leaves* the foster family's home and opportunity—as indicated and desired—to have continued constructive contacts with the child.

7. *Opportunity to develop confidence in making immediate and day-to-day decisions* in regard to the child.

8. *Consideration as possible permanent parents* for the child who, after being in their home for some time, becomes free for adoption or permanent foster family care.

9. *Opportunity to learn and grow* in their vocation.

10. *Opportunity to be listened to regarding agency practices* that they may question.

11. *Full reimbursement for costs* of the foster child's care.

12. *Salary and all fringe benefits* available to other agency staff members.

13. *All rights accorded the agency's personnel,* including a procedure for a fair hearing and liability coverage.

Responsibilities

For every right there is, of course, a counterpart responsibility that is an integral part of the foster parents' overall responsibility to further the agency's goals for the child. Whether the child is to be returned to his own parents, to be placed for adoption, to go into some other type of foster care, or to remain with the foster parents until ready for self-dependence, the foster parents have a major responsibility for preparing him for what lies ahead. If the goal is to return the child, this responsibility includes encouraging contacts between the child and his own parents rather than becoming a barrier between them.

an essay review

PIAGET'S THEORIES and EARLY CHILDHOOD EDUCATION

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The developmental theories of the noted Swiss psychologist, Jean Piaget, have been made more comprehensible by the recent publication in this country of four books * that present much needed explanations of his theory of the development of intelligence.

Perhaps the most notable of the four is Piaget's "The Psychology of the Child," in which he has attempted to summarize his developmental theories in a single concise volume. This book, along with Ginsburg and Opper's "Piaget's Theory of Intellectual Development—An Introduction" and Beard's "An Outline of Piaget's Developmental Psychology for Students and Teachers," which are also primarily summaries of Piaget, are welcome additions to the literature on learning. These publications should prove especially helpful to persons seeking a first acquaintance with Piaget since his developmental theory is spread over numerous volumes and articles, many of which make difficult reading and some of which are available only in French.

"The Psychology of the Child" should help to dispel some of the mystique that has come to surround Piaget's theories—often because of a basic misunderstanding of his theoretical standpoint and also because of his difficult writing style. Piaget begins by making clear that his book has to do with "genetic epistemology" and not directly with "child psychology." According to Piaget, the difference is that child psychology is the study of the child for its own sake, whereas genetic epistemology is the study of the child for the purpose of solving problems relating to the origins of knowledge, intelligence, and logic.

In his work, Piaget has taken up the problem of the origin of ideas and attempted to determine the relationship between experience gained through the senses and the logical structures of intelligence. Perhaps much of the misunderstanding of Piaget begins with the mistaken idea that he is addressing himself to the more conventional research problems of the child psychologist.

Piaget's theory of learning is unlike the learning theories of experimental child psychologists in being oriented toward the development of the structure of intelligence. As Ginsburg and Opper so aptly point out, Piaget distinguishes between two types of learning: (1) The learning of specific responses to specific situations; and (2) the development of cognitive structures of intelligence and higher levels of assimilation. Conventional child psychologists are concerned with the former; Piaget with the latter.

A developmental theory

In "The Psychology of the Child" Piaget enumerates four primary influences on intellectual development and consequently on learning: (1) The child's physical structure, that is, the body and its functions; (2) experience, in the form of activity, involving interaction of the child with his environment; (3) social experiences involving the learning of behavior related to a specific sociocultural environment; and (4) the self-regulatory mechanism, "equilibrium," which produces a balance between the assimilation of new experiences and accommodation of them to what is already known at any given developmental level.

Piaget, as the four summaries make clear, is primarily interested in building a theory of the structure of intelligence through experimental investigation. His theory of intelligence is concerned with three underlying factors: Content, function (or operation), and structure.

The content of intelligence consists of the data gained through sensory motor experience. The function or operation of intelligence consists of an inherited manner of dealing with the environment involving two primary processes: *Organization* of the existing cognitive structures and *adaptation* of new experiences (including assimilation and accommodation).

The structures of intelligence are the series of cognitive structures that Piaget calls schemata. Each schema is a

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*THE PSYCHOLOGY OF THE CHILD. Jean Piaget and Barbel Inhelder. Basic Books, New York, N.Y. 10016. 1969. 173 pp. $5.95. THE MECHANISMS OF PERCEPTION. Jean Piaget. Basic Books, New York, N.Y. 10016. 1969. 480 pp. $12.50. PIAGET'S THEORY OF INTELLECTUAL DEVELOPMENT—AN INTRODUCTION. Herbert Ginsburg and Sylvia Opper. Prentice-Hall, Inc., Englewood Cliffs, N.J. 07632. 1969. 237 pp. $2.95, paperback; $6.95, clothbound. AN OUTLINE OF PIAGET'S DEVELOPMENTAL PSYCHOLOGY FOR STUDENTS AND TEACHERS. Ruth M. Beard. Basic Books, New York, N.Y. 10016. 1969. 139 pp. $4.95.

concept of reality based on the generalization and differentiation of repeated experiences.

Learning, according to Piaget, involves the construction, organization, and alteration of existing schemata to form new schemata that incorporate more complex cognitive sequences at the action, symbolic, and operational levels of development.

In Piaget's theory of development, perception occurs in conjunction with sensory-motor activities and intellectual operations but does not account primarily for the growth of intelligence. In "The Mechanism of Perception," Piaget suggests two possible hypotheses regarding the relationship of intelligence to perception: (1) a direct connection between perceptions and cognitive structures by means of sensory-motor activities, and (2) "the autonomous development of intelligence from action (sensory-motor activities), accompanied by a continuous enrichment of perceptual structures under the influence of the development of structures of action and of intelligence." Piaget adopts the latter hypothesis for several reasons, including his finding that "notions originate in sets of actions and operations which begin with sensory-motor organization, of which perceptual activities represent only a particular sector."

Thus, Piaget places perception in a subsidiary role in learning compared with sensory-motor and operational activities.

The role of motivation in Piagetian theory is somewhat akin to the "competence" theory of R. W. White.[1] Both suggest that the motive for learning is to gain mastery or competence in relation to the environment. In Piaget's theory, motivation for learning is not the need to achieve a goal deemed worthy by external standards, nor the need to reduce tension, but rather the intrinsic need to exercise the assimilation-accommodation processes for the purpose of developing cognitive structures for dealing with the environment.

Some effects

One result of Piaget's developmental theories has been the recognition of the crucial effect of early childhood experiences and the importance of early childhood education in the development of the child.

Perhaps the major attempt to translate the developmental theories of Piaget into some kind of a theory of instruction has been the work of Jerome Bruner,[2] who has focused on those factors in Piaget's formulations that appear to be within the control of the psychologist and the educator—the structure of the environment and the arrangement of the proper "match" between the individual developmental level and the environment. Bruner's concept of intelligence is perhaps best explained in his theory of "instrumental conceptualism." The general framework of the theory is similar to Piaget's "assimilation–accommodation" model, although, in attempting to relate his model to psychology and education, Bruner has placed a much greater emphasis on *psychological processes* (such as memory and transfer of training to learning) and the structure of the environment.

Bruner's concern with "the match"—that is, matching teaching methods to the child's stage of development—has been translated into his theorem of readiness: ". . . any subject can be taught effectively in some intellectually honest form . . . to any child at any stage of development." [2] This statement has often been interpreted to mean that Bruner is in essential disagreement with Piaget regarding the necessity of age-bound (as opposed to sequence-bound) stages of development. On the contrary, Bruner accepts the invariant sequence of the stages, but seems to regard the age-bound nature of the stages as a general description of what might occur on the average.

Misinterpretations of Bruner arise from failure to recognize that any subject can be taught to any child *only* when the method of instruction is in accord with the child's developmental level. Teaching a subject involves teaching it in one of three cognitive modes comparable to the three major stages of Piagetian development: (1) sensory-motor, (2) perceptual, and (3) operational. Although a child may not understand or be ready to learn a concept at the operational or logical level, he may be ready for basic "understanding" of it, in the form of sensory-motor manipulation or perceptual experience. This suggests that a challenge for research in early childhood education is in the development of educational experiences, materials, and methods to provide the specific kinds of sensory-motor and perceptual experiences that facilitate progress toward operational thinking.

In the absence of knowledge based on such research, many early childhood educators have attempted "crash programs" to bring so-called "culturally disadvantaged" children up to the norm. Piaget's sequential theory of intelligence suggests that such programs may be doomed to failure because they may not be developing the kinds of skills that will build upon one another in the sequence of sensory-motor, perceptual, and operational levels. They attempt to rush into a particular subject matter with symbolic methods that may not be transferrable to other subject areas. Piaget (or Bruner) might argue that the culturally disadvantaged should be taught in the same sequential fashion as other children. For example, to understand algebra on the operational level the child would need first to have engaged in some sensory-motor activities that would give him a practical basis for understanding the meaning of the algebraic symbols.

Implications

One of the notable aspects of both the Ginsburg-Opper and the Beard volumes is the attempt to present some of the implications of Piaget's theories for education.

Ginsburg and Opper suggest the following educational guidelines based on Piagetian theory:

1. Since the language and thought of the child are qualitatively different from the adult's, the teacher should attempt to determine how they are different, or, more specifically, the level of intelligence at which the child is operating. Attempts have been made to put this idea to practice by encouraging children to learn through exploration and discovery (discovery-learning) and through experiments, such as those at the Ontario Institute for Educational Studies that are concerned with the match between the conceptual levels of pupil and teacher.[3]

2. Children learn best from activity. According to Piaget (and also John Dewey), learning is doing, and the child makes substantial progress when he has abundant opportunities for sensory-motor activities. Perhaps then, the major challenge for early childhood educators is the determination of the *specific*

activities that constitute a proper background for developing such conceptual activities as language and logic. Much research remains to be done in this area.

3. With regard to achievement motivation, Piaget's theory suggests that the notion of "interest" is primarily an intrinsic quality dependent on the degree to which the subject matter presented to the child is related to his level of intelligence or to what he already knows. Piaget postulates the self-accommodation process, the natural flow to equilibrium between new learning and what is already known, and the natural exercise of cognitive structures under appropriate stimulation. These assumptions lead him to suggest that "the child is more apt to modify his cognitive structures in a constructive way when he *controls* his own learning" then when rewards for learning come primarily from external sources.

Some recent research seems to bolster the theory that motivation is based, in part, on the child's perception of himself as the *locus of control* for his actions.[4]

At the present state of early childhood education, the implications of Piaget's theories, while important, are of a most general nature. However, the general application of Piagetian theory may eventually be translated into knowledge and control of the specific psychological processes of stage transition.

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GUIDES and REPORTS

HUNGER: an action guide. Marguerite Gilstrap. National Board of the Young Women's Christian Association, 600 Lexington Avenue, New York, N.Y. 10022. 1969. 16 pp. 40 cents; five or more copies, 35 cents each.

Outlines steps that local organizations can take to create public awareness of hunger and malnutrition, to learn about programs of food assistance in their areas, and to spearhead action to secure such programs where they are not available.

MINNESOTA SYMPOSIA ON CHILD PSYCHOLOGY, VOLUME 3, John P. Hill, editor. University of Minnesota Press, Minneapolis, Minn. 55414. 1969. 163 pp. $5.

Includes six papers presented at the third annual Minnesota symposium on child psychology, sponsored by the Institute on Child Psychology, University of Minnesota. They report research dealing with stimulus familiarization, early stimulation and cognitive development, stimulus selection, the implications of animal studies, natural reference groups during adolescence, and components of sibling interaction.

CHANGING SERVICES FOR CHANGING CLIENTS. Columbia University Press, 440 West 110th Street, New York, N.Y. 10025, for the National Association of Social Workers. 1969. 127 pp. $3 (paperback).

Includes selected papers discussing the effects of social changes on people, on social services, and on the delivery of services.

ADDENDA TO STANDARDS FOR HOMEMAKER-HOME HEALTH AIDE SERVICES. National Council for Homemaker Services, Inc., 1740 Broadway, New York, N.Y. 10019. 1969. 32 pp. $1.

Presents additional standards to those published by the National Council for Homemaker Services in 1965.

PRELUDE TO ACTION: report of the Maternity Center Association's 50th anniversary seminar on childbearing and family life, held March 31–April 3, 1968, at the Princeton Inn, Princeton, N.J. Maternity Center Association, 48 East 92d Street, New York, N.Y. 10028. 1969. 170 pp. $3.

Contains summaries of five group discussions presented at a seminar on the problems of providing maternity care and ways these might be solved.

THE FUNCTION OF REBELLION—IS YOUTH CREATING NEW FAMILY VALUES? Child Study Association of America, 9 East 89th Street, New York, N.Y. 10028. 1969. 83 pp. $2.45.

Proceedings of the Child Study Association's 1968 conference, designed to explore the roots and aims of today's rebellious youth and the responsibility of adults and social institutions for opening meaningful channels of communication between the generations.

EASTER SEAL GUIDE TO SPECIAL CAMPING PROGRAMS. Helen Crane, editor. Task Force on Special Camping, National Easter Seal Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago, Ill. 60612. 1969. 106 pp. $1.50.

Offers guidelines for the development and administration of special camping programs for handicapped children.

THE ROLE OF THE OPHTHALMOLOGIST IN DYSLEXIA. Institute for Development of Educational Activities, Inc., Box 446, Melbourne, Fla. 32901. 1969. $1.

Reports on a seminar designed to clarify some of the confusion surrounding dyslexia, or learning disabilities, and to determine the ophthalmologist's role in diagnosis and treatment.

BOOK NOTES

PROTECTION OF VISION IN CHILDREN. Arnall Patz, M.D., and Richard E. Hoover, M.D. Charles C Thomas, Publisher. Springfield, Ill. 1969. 171 pp. $10.

Addressed to pediatricians, family physicians, paramedical workers, school officials, volunteers, parents, and teachers who deal with children, this book presents principles and methods of prevention, early detection, and management of visual problems. The authors, both faculty members of the Johns Hopkins University School of Medicine, emphasize the importance of detection of visual defects in preschool children to allow proper treatment at a time when chances for success are greatest.

Recently developed screening tests, management of the child with severe visual impairment, and first-aid care of eye emergencies at school and at home are dicusssed. The book also describes the roles of the obstetrician, the pediatrician, the family physician, and the genetic counselor in prevention and detection of visual defects.

DELINQUENCY: Selected studies. Thorsten Sellin and Marvin E. Wolfgang, editors. John Wiley & Sons, Inc., New York, N.Y. 1969. 161 pp. $7.95.

The first chapter of this book describes an "index of delinquency" developed by the editors in the early 1960's to measure the amount and seriousness of juvenile offenses, taking into account both the number of law violations and their character and degree of seriousness. Taking police data on delinquency as the basis for the index, the editors questioned the validity of the principles of classification used in police reports and developed a new system of classification to reveal the variants within the usual classifications.

This book presents six studies of application of the index, carried out as extensions of the basic research, studies of: (1) the distance between a location of an offense committed by a person under 18 years of age and his home; (2) the ecology of juvenile delinquency; (3) the delinquency of gangs and spontaneous groups; (4) internecine conflict and characteristics of the offender; (5) factors that influence the police disposition of juvenile offenders; and (6) trends in robbery measured by different indexes.

The six studies made with the cooperation of the Police Department of Philadelphia were carried out by four former graduate students in criminology or sociology at the University of Pennsylvania, all of whom participated with the editors in the original research: Stanley Turner, Bernard Cohen, William H. Hoehstein, and Andre Normandeau.

THE CHILDREN: a personal record for the use of adoptive parents. Jan de Hartog. Atheneum Publishers, New York, N.Y. 1969. 265 pp. $6.50.

The joys and trials of adopting two Korean girls, 5 and 3 years of age, are described by writer Jan de Hartog in this collection of "random notes on the practical aspects of interracial adoptions." Drawing on his own experiences and those of more than a hundred couples in the United States who have adopted young Asian children of mixed parentage, the author discusses the arrival of the child, the everyday difficulties of settling down, and the gradual development of family life.

The author explores many of the problems that face the adopted child and his new parents: among others, the transition for both child and parents from the idealized picture of the new family to the realistic acceptance of other family members for their own sake, the child's need for security, the periods of "blind, witless panic" that affects parents in the first few weeks, the importance of routine, the confusion of too many choices, the differences in the way Asian and American children play. The author tells how he and his wife met some of these problems. When he felt guilty about spanking one of his adopted daughters, he was reminded by another adoptive father that "anger happens to be a proof of concern," and furthermore, "the knowledge that you care" is one of the greatest gifts a parent can give his child.

The author tells about some of the Asian children who seem to have adapted to a new family, but who have merely retreated into a secret world where "nothing touches them much." A child who has been so severely damaged emotionally may need considerable time to change, he says, but suddenly such a child will become "demanding, moody, jealous, and afflicted by the insatiable need for affection." He advises parents: "Make sure that after the battle of the day you give him what he really came for: lots of love and tenderness."

THE OTHER 23 HOURS. Albert E. Treischman, James K. Whittaker, and Larry K. Brendtro. Foreword by David Wineman. Aldine Publishing Co., Chicago, Ill. 1969. 240 pp. $7.

This book deals with the management of daily events in the lives of emotionally disturbed children in residential care—the 23 hours that such children spend outside of psychotherapy. It discusses ways that child care workers can use communication, social reinforcement, and "modeling"—that is, providing through their own behavior patterns that the child can imitate—to establish constructive relations with maladjusted children.

Chapters provide suggestions for program activities; managing the periods of waking up, mealtime, and bedtime; temper tantrums; and otherwise creating a therapeutic milieu. Methods of observing and recording children's behavior are also presented.

The authors give many illustrations from their work at the Walker Home for Children in Needham, Mass., a residential home for severely disturbed boys, and the University of Michigan Fresh Air Camp for emotionally disturbed delinquent children. They stress the importance of developing the technical skills and self-awareness of child care workers and at the same time "involving high-level personnel in everyday child life issues."

HERE and THERE

White House Conferences

About 15,000 persons are expected to attend six regional White House Conferences on Children to be held in November as precursors to the national conference, which is scheduled to meet in Washington, D.C., December 13–18, 1970. Some 3,000 delegates will attend the Washington meeting.

The regional conferences will be held in the following cities: Portland, Oreg., Denver, Colo., Omaha, Nebr., Indianapolis, Ind., Tampa, Fla., and Pittsburgh, Pa. Along with the Washington conference in December, they will be focused on the problems of children from birth through the age of 13.

People to participate in discussion panels for these conferences are now being selected by the conference staff in consultation with various State and national organizations. Material for their consideration is being developed from a variety of sources, including seminars and workshops currently being conducted at the conference headquarters in Washington, meetings held by the State committees on children and youth, and suggestions received from professional and voluntary organizations.

Ballots for the election of a chairman, vice chairman, and secretary for each regional conference were mailed in March to the 55 chairmen of State and Territory committees on children and youth. The final selections were made on April 15, 1970.

Preparation for the youth phase of the White House Conference to be held in Washington, D.C., in June 1971, is also underway. Approximately 120 summer interns are being selected through the Federal service entrance examination, the Washington intern program, the White House, the State committees on children and youth, and a special civil service program to include disadvantaged young people. They will work in three major areas: (1) Examination of Federal programs relating to youth; (2) research into issues that have particular impact on youth; and (3) communication with the various segments of the public interested in the White House Conference.

The examination of Federal programs that affect young people will be carried out by a youth task force headed by Frank D. Raines, now a junior at Harvard University. A staff of 60 young people, primarily college students, will work from June 15 to September 1 in Federal agencies concerned with nine specific areas: Education, employment, crime and justice, health, legal rights, the military and the draft, public service, consumer affairs, and recreation and environment.

The youth task force will determine which programs significantly affect youth, evaluate their effectiveness, recommend changes in current practice, and specify the kind of innovative action needed. Their findings will be presented to the administration for consideration in developing a national youth policy, according to Stephen Hess, chairman of the White House Conference. The formulation of such a policy was recommended to the President and his Cabinet by the staff of the Urban Affairs Council in September 1969.

Welfare rights

On March 23, 1970, the Supreme Court of the United States in a 5–3 decision ruled that public assistance payments, under either Federal-State programs or general relief programs, may not be stopped until recipients whose eligibility is in question have had opportunity for an evidentiary hearing. The ruling upheld a decision of a Federal district court in New York requiring New York City to hold hearings before cutting off public assistance payments and reversed a decision by a Federal court in California that sustained the State's practice of stopping public assistance payments after opportunity for a conference, but not a hearing.

In the majority opinion Justice William J. Brennan said that the hearings must give the recipient, among other things, a chance to be heard in person, to know on what evidence and reasons he is deemed ineligible, to cross-examine witnesses and to retain a lawyer if he chooses. Justice Brennan specifically pointed out that the Court was not saying that counsel must be provided for the recipient, but he noted that counsel could be helpful.

Child care

A 3-year, $3 million project to develop and demonstrate model day care programs in the eight Southeastern States is being launched this spring with the use of both Federal and private funds. State family and child welfare agencies in Alabama, Mississippi, Georgia, Florida, Kentucky, North Carolina, South Carolina, and Tennessee are participating. Each State's project will emphasize a different aspect of day care or other form of part-time child care.

The William H. Donner Foundation of New York City is investing $250,000 a year in the programs and the Department of Health, Education, and Welfare is allocating a total of $750,000 a year under title IV–A of the Social Security Act, which provides for services to strengthen family life. States and localities are also contributing facilities, services, and funds.

The Southern Regional Education Board of Atlanta, Ga., coordinator for the project, is providing training and evaluation for all programs. SREB is working with a committee of officials from eight States and the Office of Child Development and the Social and Rehabilitation Service of the Atlanta regional office of HEW.

The programs will serve children from 6 months to 14 years of age. The demonstrations include care for children under 3 years of age, afterschool and overnight care, summer care, use of

mobile facilities, training and use of "floating" day care mothers who can go where needed, contracts with private agencies for comprehensive child care services, and use of citizens' advisory committees. All programs are designed to give the States experience in operating programs and in supervising operations by public and private agencies to meet the needs of children and their families.

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A 2-day Conference on Industry and Day Care was held at the Center for Continuing Education, University of Chicago, on March 18–20. Sponsored by the Urban Research Corp. of Chicago, the conference brought together 125 representatives of industry, specialists in early childhood development, and Federal, State, and local officials to discuss ways in which the industries might provide day care services to the children of their employees.

In the keynote address, Henry Morgan, manager of human relations for the Polaroid Corp., described the demonstration day care project funded by the Children's Bureau of the KLH Co. in Cambridge, Mass., with which he had previously been associated. The conference also heard from representatives of AVCO Corp., Mr. Apparel Co., and the Skyland Textile Co., all of which have established day care centers in their plants.

Invited to raise what they considered to be major issues relating to industrial involvement in day care programs, the conferees brought up such questions as whether the best site for an industrial day care center was near the home or near the plant; whether the financial outlay required to provide day care is paid off in reduction of absenteeism and employee turnover; whether or not parent involvement in the day care program should be compulsory; what Federal funds are available for day care and how industries might qualify for them; and how industries can be educated to the broad social goals involved in providing constructive day care programs, rather than simply custodial care.

Small workshop groups discussed licensing requirements for facilities; program goals; the 4–C program, sponsored by the Office of Child Development to encourage coordination of local day care services for children; franchise arrangements; and ways in which industry, communities, and the Federal Government might cooperate in creating citywide model day care centers.

The conference concluded with talks by Jule M. Sugarman, acting director of the Office of Child Development, on the costs of day care and sources of funding, and by Congressman John Brademas of Indiana, chairman of the House Select Subcommittee on Education, on pending Federal legislation relating to day care.

Adoption

To help States build up adoption resources for black children and children of mixed racial background—where the gap between resources and need is greatest—the Children's Bureau is planning a nationwide recruitment effort.

As a first step, it has selected a group of skilled interviewers to talk with people in five large cities to secure their suggestions and opinions on ways of increasing the number of adoptive homes, and to determine their willingness to help in the development of a recruitment plan in their localities. Persons interviewed will include adoptive parents and representatives of social agencies, and organizations interested in the problem, including organized black groups.

Among other subjects to be discussed will be the potentialities of transracial adoptions and subsidized adoptions for helping to meet the problem. The cities in which the interviews will take place are New York, N.Y., Washington, D.C., Atlanta, Ga., Chicago, Ill., and Los Angeles, Calif.

After the results of the interviews are analyzed, a national committee will be formed to set up the machinery for stimulating local recruitment efforts to secure adoptive parents for black children and children of mixed racial background.

A similar project will be launched later to recruit adoptive homes for children with special needs, including physically and emotionally handicapped children, older children, and groups of children of the same family.

Children's teeth

No significant racial or geographic differences were found in a recent study comparing the amount of tooth decay in black teenagers and white teenagers in Detroit, Mich., and Columbia, S.C., according to a report made at the International Association for Dental Research in New York in mid-March. The study, carried out by Robert A. Bagramian, D.D.S., assistant professor of dentistry and public health at the University of Michigan, was originally designed to test the widely accepted theory that racial and geographic factors affect amounts of tooth decay.

At the time of the study, neither city's water supply contained fluoride. All of the young people examined—696 of both races in Detroit and 891 of both races in Columbia—were high school students who had grown up in the city in families of low socioeconomic status. Young people of both sexes were included. When the statistical findings of "caries experience" were broken down for eight groups—males of each race in each city, and females of each race in each city—all showed high averages of decayed, missing, or filled teeth per child:

- Black males in Detroit—9.45; white males in Detroit—10.85.
- Black males in Columbia—11.07; white males in Columbia—10.78.
- Black females in Detroit—9.78; white females in Detroit—11.59.
- Black females in Columbia—11.20; white females in Columbia—10.89.

In comparing his findings with the findings of studies estimating the incidence of caries experience in the black population as a whole, Dr. Bagramian found a higher incidence of caries experience among the black urban high school students. He suggests an explanation for this might be that the migration of Negroes from rural to urban areas has been accompanied by a change in diet patterns involving the ingestion of more sugar—a contributing factor in caries experience.

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The National Institute of Dental Research of the National Institutes of Health is planning a 10-year national caries program to make tooth decay almost completely preventable by 1980. According to the Institute, dental caries—or tooth decay—affects 98 percent of the people in the United States and is the most prevalent affliction of children. A child entering school has an average of three decayed teeth and a 15-year-old child has an average of 11 decayed teeth.

The national program will emphasize continued research into the cause, con-

trol, and prevention of caries and the development of techniques that can be incorporated into personal oral health programs and community health services. Based on the recommendations of a dental caries task force appointed in 1969 and the results of dental research conducted and supported by the Institute, the program will use three approaches to prevention of dental caries:

- ***Protecting the teeth*** through the development of new methods to provide fluoride to the 40 million Americans who do not now have access to fluoridated water supplies, including such means as the addition of fluoride to salt and the application of fluoride-containing gels to the teeth. Efforts will also be made to perfect adhesive sealants that protect the chewing surfaces of the teeth.
- ***Modifying the diet*** through the development of substitutes for ordinary table sugar; addition of phosphates to such foods as flour, salt, milk, and snacks; and further investigation of the preventive value of adding trace elements to foods and water.
- ***Combating bacteria*** through the use of enzymes to prevent or remove bacterial plaque—gummy masses of bacteria—and the application of antibiotics and antiseptics.

The national caries program will also focus attention on the need for tooth restoration, using new materials and tooth implants.

Rubella

In the first 8½ months of the nationwide "Stop Rubella" campaign coordinated by the Public Health Service, rubella vaccine was administered to about 4.8 million children, or just over 10 percent of the 44.5 million children in the United States within the target age group, according to the reports to the National Communicable Disease Center. The 5-year cooperative State-Federal campaign against rubella, which began July 1, 1969, is designed to vaccinate all children between 1 year of age and puberty (in most States, 11 years of age; in a few others, 10 years of age). Children are considered the main source of spread of rubella, a disease that may cause severe defects or death in the fetus of a pregnant woman. (See "Rubella and Its Aftermath," by Janet B. Hardy, CHILDREN, May–June 1969.)

Federal rubella grant funds have provided about 2.4 million doses of rubella vaccine, or half of the vaccine used in the campaign thus far. The other half has been provided under State or local funds and other Federal funds such as those available under title I of the Elementary and Secondary Education Act.

With the licensing of two additional types of rubella vaccine by the Department of Health, Education, and Welfare, the campaign will be accelerated within the coming months. Philips Roxane Laboratories of Columbus, Ohio, received the second license in December 1969 for a vaccine grown in canine tissue. The third license was granted in March 1970 to Recherche et Industrie Therapeutiques, a Belgian subsidiary of Smith Kline & French Laboratories of Philadelphia, Pa. The RIT vaccine is produced in rabbit kidney cell cultures. The first license was issued to Merck Sharp & Dohme of Rahway, N.J., in June 1969 for a vaccine grown in duck embryos.

Young parents

Ten young parents, age 20 or under, met in mid-March with members of the Subcommittee on Parent and Family Life Education of the Interdepartmental Committee on Children and Youth to consider the implications of teenage parenthood for government policy and for programs of family life education. They included four married couples, one married mother without her husband, and one unmarried mother. All had become parents before the age of 18. They came from the inner city, working class suburbs, the Army, and an Indian reservation.

In addition to the young parents the consultants to the subcommittee included two nongovernmental professional persons—a psychologist, Helen Southard of the staff of the National Board of the Young Women's Christian Association, and a sociologist, Jessie Bernard of Pennsylvania State University. James Lieberman of the National Institute of Mental Health and Carlotta Miles of Howard University led the discussion.

In spite of their differences in background, the young parents bore testimony to some common problems: economic difficulties generally; the catastrophic effects of medical expenses; the inability to afford decent housing; the lack of resources for good day care; the inability to pursue further education; the lack of suitable opportunities; the lack of information about resources to meet their problems. For example, the medical expenses of pregnancy and childbirth had forced two of the men into taking moonlighting jobs.

Two young men in the group who had Army experience spoke of the emasculating effects of not being able to meet their family responsibilities because of the restrictions of being in the military. Four of the five women expressed the wish to plan an additional child and to limit their total number of children to two.

All the young parents expressed resentment at not being treated by society as adults. For example, they had been unable to get credit or take out medical insurance. They also expressed feelings of isolation from other young people with the same problems. Those who were attending night school complained that they were not being taught well, nor really receiving much content: "not nearly as good as regular high school."

A full report of the meeting with comments on its implications for government programs, especially in relation to family life education, is to be published by the Children's Bureau in the near future.

Pediatric care

Comprehensive pediatric care is more efficient and less costly to the patient in time, money, and dissatisfaction than the fragmented care usually provided for the urban poor according to Joel J. Alpert, M.D., Margaret Heagarty, M.D., John Kosa, Ph. D., and Jean Robertson, Ph. D., as a result of a study they carried out in Boston, Mass., between 1965–69, with support from the Children's Bureau.

Families who were users of the emergency clinic of the Children's Hospital Medical Center, Boston, in 1964 were eligible for the study provided they lived within 3 miles of the hospital, had no physician who usually looked after the children, expected to live in Boston for 3 years, did not have a member who presented a high probability of developing a chronic disease, and would agree to a series of interviews.

The 931 families eligible to participate in the study were divided at

random into three groups: (1) an experimental group offered comprehensive pediatric care, (2) a contact control group, and (3) a noncontact control group. Data were collected on the first two groups at 6-month intervals over the subsequent 3 years. Families in the third group, formed for assessing interview effect, had a brief initial interview and were not contacted again until the final data collection.

Analysis of the data showed the following significant results:

- Immunizations and other preventive measures were higher in the experimental group.
- More health supervision visits were made by members of the experimental group.
- Fewer hospitalizations, surgical procedures, visits because of illness, and broken appointments occurred in the experimental group.
- Expressions of satisfaction occurred more often in the experimental than in the contact control group.
- Fewer laboratory procedures were provided members of the experimental group.

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A national Center for Research and Development in Early Education of Handicapped Children is being established at the University of Oregon in Eugene during 1970, under the Mental Retardation Facilities and Community Mental Health Centers Construction Act. The center is the first to be concerned specifically with research in the education of handicapped preschool children. It is the seventh research facility affiliated with the U.S. Office of Education's National Laboratory on Early Childhood Education, Urbana, Ill.

Services to children

About half of the requests for service received by 237 local voluntary and public child welfare and family service agencies during a 5-day period in May 1969 involved foster care or services to children in their own homes, according to a nationwide survey made by the Child Welfare League of America and supported by the Children's Bureau. Conducted by Ann W. Shyne, CWLA director of research, and Lucille J. Grow, research associate, the survey was designed to provide information for use in research planning.

Of the 3,748 total requests for service on behalf of 6,256 children, 23 percent were made for foster care; another 23 percent, for services to children in their own homes; 9 percent, for adoption service (predominately for white children); 8 percent, for day care (predominately for Negro children); 7 percent, for maternity home care; 6 percent, for homemaker service; and 20 percent, for a variety of other services, such as summer camping.

In about half the cases, the agencies planned to provide the specific service requested. About one-fifth of the requests were referred to other agencies, with referral somewhat more common for Negro clients.

The median age of the children for whom service was requested was 8.5 years, with 21 percent less than 3 years of age and 33 percent 12 years of age or older. The majority of requests—68 percent—were for services for white families; 22 percent of the requests were for Negro families.

Parents made 44 percent of the requests for service; health and welfare agencies, 26 percent; relatives, friends, and neighbors, 10 percent; the courts and police, 6 percent; schools, 6 percent; and other persons, 8 percent. Among both public and voluntary agencies, the courts were most effective in initiating service for a child; relatives, friends, or neighbors were least effective.

Reasons given to the agencies for the need for service included: emotional or behavior problem of the child, 35 percent; pregnancy out of wedlock, 11 percent; birth out of wedlock, 10 percent; illness, death, or confinement of parent, 9 percent; child abuse or neglect, 8 percent; financial need, 6 percent; parental conflict, 4 percent; other reasons, 17 percent.

Negroes made 44 percent of the requests for service received by the 13 participating public agencies, but only 16 percent of those received by the 224 voluntary agencies. A much smaller proportion of Negro families than white families sought either maternity home care or adoption service. On the basis of their findings, the researchers suggest that the voluntary agency is still regarded by its clients and the community at large as providing service primarily for the white child.

The report of the study, entitled "Requests for Child Welfare Services: A Five-Day Census," is available from Research Center, Child Welfare League of America, Inc., 44 East 23d Street, New York, N.Y. 10010. (Price: $2.)

Miscellaneous

"Jenny Is a Good Thing," an 18-minute color film produced for Project Head Start and narrated by Burt Lancaster, shows children eating, cooking, learning about food, gardening, and learning new words, colors and concepts of size, and shape, and texture through nutrition-related activities. Using children of various ethnic backgrounds, it was filmed at Head Start centers in Jacksonville, Fla.; Vincennes, Ind.; Cochiti Pueblo and Santa Fe, N. Mex.

The film was nominated for an academy award in the documentary category.

The 16-mm. film is available in English and Spanish for a 5-day rent-free loan from Modern Talking Picture Services Film Libraries in United States and Canada. It may be purchased from Precision Film Laboratories, Inc., 21 West 46th Street, New York, N.Y. 10036, for $45 per print.

A leader's discussion guide, designed to be used with the film is available from the Office of Child Development (Publication 3E in the Head Start Nutrition Kit).

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Maternal and Child Health Service, Public Health Service, has recently begun publishing a bulletin, *Maternal and Child Health Information*, designed for the exchange of information affecting the maternal and child health field. The first four issues of the bulletin, which is to appear irregularly, have reported on the implications for maternal and child health of three national conferences recently held in Washington, D.C.—a conference on maternity and infant care projects, a conference on pregnant teenagers, and the White House Conference on Food and Nutrition—and on trends in maternal and child health services, the MCHS budgetary requests for 1971, and other items bearing on health needs and services for children.

The bulletin is available without charge from Public Health Service, Health Services and Mental Health Administration, Maternal and Child Health Service, Parklawn Building, Rockville, Md. 20852.

IN THE JOURNALS

Foster care

A number of child welfare agencies are offering new understanding of the possibilities of permanent and long-term foster family care for children who must live with substitute parents for long periods during their growing years, say Bernice Madison, Ph. D., and Michael Schapiro, in the March 1970 issue of *Child Welfare*. ("Permanent and Long-Term Foster Family Care as a Planned Service.") The authors are respectively professor and associate professor of social work at San Francisco State College.

In the past, return of the child to his own home—even when parents were not ready to assume responsibility—and adoption have been considered preferable to planned foster family care, the authors explain. Pointing out that this limited choice has often led to unplanned temporary foster family care that continues for many years, they suggest that it is the poor quality of such unplanned long-term foster care—rather than the type of care itself—that has added to the children's emotional damage while in substitute homes.

Defining "long term" care as care for children who are in the custody of an agency for an extended period but whose guardianship has not been surrendered by their natural parents, and "permanent" care as care for children who are legal wards of the State and who have been transferred to an agency's guardianship, the authors explain that these differences affect the procedures but not the fundamental substance of arrangement for a child's care. They note that many children can be neither returned home nor adopted.

Pointing out that most children coming into foster care for the first time are less than 3 years of age, the authors emphasize the importance of an early decision on whether the care is to be temporary or whether the child is to be in the agency's care on a permanent or long-term basis, and—if it is to be either long term or permanent—that plans be made accordingly.

To protect the security of the child, the authors advocate the establishment of a policy requiring that once a child has been absorbed into a permanent foster family that is giving him adequate care, he is no longer available for adoption except by his foster parents. The authors report that some agencies are finding oral or written contracts with the foster parents useful in creating a feeling of permanence and security in both foster parents and child; they maintain that the quality of the discussion around permanent planning is the key to its effectiveness.

Adolescents in 1970

The majority of today's adolescents accept the established institutions of American society, play out the roles assigned to them by family, education, and occupation, and subscribe to traditional values, yet they are different from adolescents of the past, says Kenneth Keniston, director of the Behavior Sciences Study Center of Yale University School of Medicine, in the January 1970 issue of *Clinical Proceedings of Children's Hospital of the District of Columbia.* ("The Adolescent in 1970.")

To explain the psychological development of today's youth, the author cites two factors: (1) the extension of adolescence as a developmental phase, and (2) the exhaustion of the credibility of the moral values of our society through the success of technological production.

As a socially recognized and valued stage of life, adolescence is a modern concept that emerges only in our own century, the author notes. He points to economic advances that have freed many adolescents from the need to do adult work while achieving the psychological, intellectual, and technical qualities valued by society. Thus, he says, today's adolescents have an opportunity to develop themselves, with all of the agony and possibility for growth that this involves.

The author points out that some of society's values, such as the Protestant ethic that once buttressed industrial production, no longer seem relevant to many young men and women brought up in families where material plenty, social status, and political freedom are taken for granted. He describes a turning away from old values of self-control, self-discipline, and achievement and a search for new values among the young. He explains that while in some areas American society has failed, in other areas it has exceeded its earlier targets, and—lacking new targets—it has become exhausted by its success. "As a result, this is an era that brings an unprecedented and surprising upsurge in youthful discontent," he observes.

Nursing the retarded

A theory of nursing in institutions for mentally retarded children and adults that encompasses educational as well as medical functions is proposed by E. Gene Patterson, consultant to the National Association for Retarded Children, and G. Thomas Rowland, professor of early childhood education at New York University, in the March 1970 issue of *American Journal of Nursing.* ("Toward a Theory of Mental Retardation Nursing: An Educational Model.") The authors define the job of the nurse who works with mentally retarded patients as interdisciplinary in nature, involving skills derived from both physical and behavioral sciences but neither dependent on nor parallel to the practice of medicine.

According to the authors, retardation—although often physiologic in origin—is essentially a matter of decelerated or impaired cognitive functioning that in many instances is responsive to certain types of educational programs. They stress the urgency of creating a better climate within residential facilities for the mentally retarded to reduce the dehumanizing situations that result in a waste of human potential. Such a climate should encourage development

within the triad of *personal adequacy, social competency,* and *economic efficiency,* they explain, adding, "It requires the fostering of maximal autonomy on the part of the retardate."

Looking at nursing of the retarded in the foregoing context, the authors offer a new job description "written in terms of nursing rather than medicine." They suggest that their model views nursing "as having regard for the human being's efforts to establish order in the environment and for use of the established order as a basis for the development of intelligent behavior."

Residence requirements

The decision of the Supreme Court of the United States in April 1969 declaring unconstitutional all State residence requirements for eligibility for public assistance has brought no radical changes in State public assistance caseloads, maintain Norman V. Lourie and Stanley J. Brody, J. D., in the January 1970 issue of the quarterly, *Public Welfare.* ("Implications of Recent U.S. Supreme Court Decisions on Residence Requirements.") The authors, deputy secretary of Public Welfare for Pennsylvania and associate professor of social planning at the University of Pennsylvania School of Medicine, respectively, queried State welfare agencies after the Court decision about trends in public assistance payments to recipients who previously would have been classed as nonresident.

Of the 35 States and four other jurisdictions that responded, the number of nonresident recipients who were added to the rolls "somewhat" balanced the number of recipients residing in other States for whom payments were discontinued, according to the authors. Six States that had eliminated residence requirements before the Supreme Court decision reported an increase of 0.01 to 2 percent in nonresident recipients in their total caseloads resulting from elimination of the residency requirement. Pointing out that almost 50 percent of nonresident applicants in one State live in rural areas, the authors suggest that public assistance may be the partial solution to the "deep poverty" of migrant farm laborers.

In reviewing research in migration, the authors note that the most common reasons people give for moving are promises of employment and the presence of relatives in their new locality. They found that States with high levels of public assistance payments did not attract a disproportionate number of nonresidents. Pointing out that the pattern of movement in public assistance recipients is almost identical with the movement of the general population, they predict that interregional and national migration will increase. They stress their view that migration is a "normal human crisis," causing individual and family problems that the public welfare field has a responsibility to alleviate.

READERS' EXCHANGE

DOWNEY: some omissions

I would like to comment on some points made in John Downey's article in the January–February issue of CHILDREN, "Why Children Are in Jail and How To Keep Them Out," which reports a Children's Bureau study of detention in 10 States and 13 individual counties. In general the conclusions of this study support the long-held conviction of the National Council on Crime and Delinquency (NCCD) that the detention of children, whether in jail or out of it, is misused by the juvenile courts of America.

Mr. Downey's solution to the problem is to pass laws prohibiting the use of jails for juveniles without exceptions, and to provide physical alternatives to the jail. He correctly advises the establishment of: (*a*) nonsecure group homes for children who need emergency care, but not secure custody, and (*b*) overnight to 48-hour secure emergency facilities apart from the jail for children who need to be detained temporarily under continual adult supervision while arrangements are made for their release or their transfer to a regional detention center. Mr. Downey implies but does not stress that these facilities ought to be established, and available, before jail detention for children is legally prohibited. Severe penalties should be attached to such a prohibition. Otherwise such legislation will invite the continued violation of law by the very agencies which exercise authority over juvenile law violators.

Perhaps Mr. Downey did not think it necessary to point out the ill effects of child jailing to the readers of CHILDREN. Many people, however, believe that there is nothing wrong in jailing children as long as they are separated from adult prisoners, and their belief is supported by most State statutes. On the contrary, not only is the child's "delinquent self image" strengthened in jail, but too often separation from adults results either in their solitary confinement (which sometimes ends in suicide) or in their being physically and sexually assaulted by older and stronger youth for lack of supervision—even by adult prisoners.

Physical facilities are not the only alternative to the use of jail for children. NCCD's nationwide survey for the President's Crime Commission found that nearly half the children referred to juvenile courts had not committed the kinds of offenses that bring adults to trial and that more than half of those remaining were more in need of protective and preventive services than secure custody. Probation rarely provides this.

Few communities have established Youth Service Bureaus to identify the problems of these youngsters, coordinate community resources on their behalf, and see that they get help in resolving problems that contribute to their delinquency. Realistic resources for young people who are hard to reach with normal services are in short supply. Moreover, social agencies tend to reject youngsters who are involved with the juvenile justice system.

It is high time that States and communities took responsibility to fill gaps in community services for these young people instead of passing the buck to the court. NCCD will soon publish guides for Youth Service Bureaus that can coordinate and strengthen local services on behalf of young people who are more in need of assistance than jailing.

An up-to-date bibliography of detention materials, including *Standards and Guides*, is available upon request from the National Council on Crime and Delinquency.

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KATZ: *changing parents' attitudes*

"The most important question for a preschool teacher to ask herself concerning her role, style, and goals may be: *What am I doing to increase the mothers' confidence in the future of their children?*" This sentence, from the final paragraph of Lilian Katz's article, sums up one of the two provocative issues the author raises in her thoughtful, research-oriented discussion of the roles, styles, and goals of preschool teachers. ("Teaching in Preschools: Roles and Goals," by Lilian G. Katz, CHILDREN, March-April 1970.)

First, Dr. Katz points out that such research as we have indicates that parents, given a choice, tend to prefer a control-oriented role model for teachers over three other models: Content-oriented, discovery-oriented, and sympathy-oriented. Furthermore, she reports, the younger the child, the more the parent is likely to prefer a "control-oriented" teacher. Few preschool teachers would feel this is an appropriate role model.

The difference between mothers' and teachers' ideas of teaching may depend basically upon what Jane Loevinger wrote of some time ago as "implicit theories of learning." Perhaps the parents are affected by the old Protestant ethic—the assumption that a child should do what his parents wish him to do because it is the right thing for the child to do. Reward is not to be provided by what one ought to do, anyway, but punishment is to be provided for transgressions.

It has been my experience, and that of my fellow workers as we have spent time with parents of young children, that it is difficult, although not impossible, to change parents' preference for control-orientation to one more inclined to positive reward. After guided observation in our classroom for a dozen mornings, one of our low-income mothers suddenly said: "I guess this shows you really don't need to beat kids to get them to learn."

A pitiably small insight, perhaps, but its slowness in coming would suggest how deeply entrenched is the control model, and a conviction that punishment is the way to change behavior. Working closely with parents in our groups, we have tried to help them see that a child in a preschool setting can acquire a skill and the understanding important to the parent, and how it can be done, and done more effectively, through a positive rather than a negative method of control.

Establishing this kind of working relationship with the parent may well be the preschool teacher's most important role of the future. We should be grateful to Lilian Katz for making the point so clearly.

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international publications

WORKLOADS IN CHILDREN'S DEPARTMENTS. Eleanor Grey. Her Majesty's Stationery Office, London, England. U.S. distributor: Sales Section, British Information Services, 845 Third Avenue, New York, N.Y. 10022. 1969. 75 pp. $1.50.

This is a report of a time study of staff time in the children's departments of authorities (county welfare departments) in England and Wales operating services to children under the British Children's Act of 1948.

GENETIC FACTORS IN CONGENITAL MALFORMATIONS: report of a WHO Scientific Group. World Health Organization Technical Report Series, U.S. distributor: American Public Health Association, Inc., 1740 Broadway, New York, N.Y. 10019. 1970, No. 438. 42 pp. $1.

This report examines the part played by genetic factors in some of the more common birth defects, the etiology of which is still poorly understood—such as cleft lip and cleft palate, dislocation of the hip, and spina bifida.

These conditions are examined in respect to their familial incidence, the effect of sex on the risk of recurrence, the relation of the risk of recurrence to population frequency, the effect of the migration of populations, and interracial crossing.

CHILDREN'S GAMES IN STREET AND PLAYGROUND. Iona and Peter Opie. Oxford University Press, New York, N.Y. 1969. 317 pp. $9.50.

Games that British children play spontaneously without equipment or adult supervision are described in this book, which lists 2,500 names for games that are popular among 6- to 12-year-olds. The authors obtained many versions of active nonsinging games from about 10,000 school children during a 10-year study that ended in 1969.

The authors have grouped the games by activity: chasing, catching, seeking, hunting, racing, duelling, exerting, daring, guessing, acting, and pretending. The book includes rhymes spoken during play, histories of traditional games, and comparisons of the similarities between British games and those of other countries.

U.S. Government Publications

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SUICIDE AMONG YOUTH: a review of the literature, 1900–67. Richard H. Seiden, Ph.D., HEW, PHS, National Institute of Mental Health. PHS publication No. 1971. 1969. 65 pp. 65 cents.

Discusses the epidemiology of suicide among adolescents and reviews published studies of adolescent suicidal behavior, with tables, figures, and bibliography; issued as a supplement to the *Bulletin of Suicidology*.

TEENAGERS DISCUSS THE "GENERATION GAP." Elizabeth Herzog, Cecelia E. Sudia, Barbara Rosengard, and Jane Harwood. HEW, OCD, Children's Bureau. Youth Reports No. 1. 1970. 36 pp. Free from OCD.

Presents the first in a series of Children's Bureau reports of the opinions of young people on problems that concern them, based on 251 returns from mail survey, or 63 percent of a panel of high school students enrolled in college preparatory courses in 12 metropolitan areas. Includes summaries of the opinions with excerpts from the teenagers' correspondence.

HEALTH SERVICES FOR MOTHERS AND CHILDREN under title V, Social Security Act. HEW, PHS, Maternal and Child Health Service, Rockville, Md. 20852. Publication OM–2074. 1969. 11 pp. Free from MCHS.

Describes grant programs related to the health of children administered by the Maternal and Child Health Service, Health Services and Mental Health Administration, including Federal-State programs for maternal and child health and crippled children's services; special projects for maternity and infant care, the health of preschool and school-age children, and dental health of children; personnel training; and research.

HOW TO PLAN A DRUG ABUSE EDUCATION WORKSHOP FOR TEACHERS. HEW, PHS, National Institute of Mental Health. PHS Publication No. 1962. 1969. 35 pp. 25 cents.

Presents guidelines for planning and conducting various types of inservice training for teachers on drug education, developed by two affiliates of the National Education Association—the American Association for Health, Physical Education, and Recreation, and the National Science Teachers Association.

CAREER OPPORTUNITIES IN SERVICE TO THE DISADVANTAGED AND HANDICAPPED. Sponsored by HEW. HEW, Office of Education. Publication No. OE 37059. 1969. 39 pp. 30 cents.

Lists training programs supported by agencies within the Department of Health, Education, and Welfare for persons interested in serving the disadvantaged and handicapped.

NUTRITION EDUCATION FOR YOUNG CHILDREN: adventures in learning—a guide for teachers and aides. Nutrition Publication 3F. 1969. HEW, OCD, Project Head Start (Washington, D.C. 20201). 64 pp. Free from OCD.

Presents suggestions about helping young children learn about food and how to establish good food habits, with recipes and projects suitable for children's use in Head Start.

HEW refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; SRS, to Social and Rehabilitation Service; PHS, to Public Health Service.

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